Local Education Agency

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General Information

Introduction

The Virginia Medicaid Provider Manual describes the role of the provider in the Virginia Medical Assistance Program (Medicaid). To provide a better understanding of the Medicaid Program, this manual explains Medicaid rules, regulations, procedures, and reimbursement and contains information to assist the provider in answering inquiries from Medicaid members.

The manual can also be an effective training and reference tool for provider administrative personnel, since it conveys basic information regarding the Medicaid Program, covered and non-covered services, and billing procedures. Proper use of the manual will result in a reduction of errors in claims filing and, consequently, will facilitate accurate and timely payment.

In addition to the Medicaid Program, other programs administered by the Department of Medical Assistance Services (DMAS) include the Family Access to Medical Insurance Security (FAMIS) program, the State and Local Hospitalization (SLH) program, and the Uninsured Medical Catastrophe Fund. If you have any questions concerning the Medicaid Program or any of the other programs listed above, please contact the provider "HELPLINE" at:

804-786-6273 Richmond Area

1-800-552-8627 All other areas

Program Background

In 1965, Congress created the Medical Assistance Program as Title XIX of the Social Security Act, which provides for federal grants to the states for their individual Medical

Assistance programs. Originally enacted by the Social Security amendments of 1965 (Public Law 89-97), Title XIX was approved on July 30, 1965. This enactment is popularly called "Medicaid" but is officially entitled "Grants to States for Medical Assistance Programs." The purpose of Title XIX is to enable the states to provide medical assistance to eligible indigent persons and to help these individuals if their income and resources are insufficient to meet the costs of necessary medical services. Such persons include dependent children, the aged, the blind, the disabled, pregnant women, and needy children.

The Medicaid Program is a jointly administered federal/state program that provides payment for necessary medical services to eligible persons who are unable to pay for such services. Funding for the Program comes from both the federal and state governments. The amount of federal funds for each state is determined by the average per capita income of the state as compared to other states.

Virginia's Medical Assistance Program was authorized by the General Assembly in 1966 and is administered by the Virginia Department of Medical Assistance Services (DMAS). The Code of Federal Regulations allows states flexibility in designing their own medical assistance programs within established guidelines. Virginia Medicaid's goal is to provide health and medical care for the Commonwealth's poor and needy citizens using the health care delivery system already in place within the state. In 2003, the Virginia General Assembly changed the name of the Medicaid program covering most children to FAMIS Plus. The change in name was intended to facilitate a coordinated program for children's health coverage including both the FAMIS (Family Access to Medical Insurance Security Plan) and FAMIS Plus programs. All covered services and administrative processes for children covered by FAMIS Plus remain the same as in Medicaid. While the Virginia Medicaid Program is administered by DMAS, the eligibility determination process is performed by local departments of social services through an interagency agreement with the Virginia Department of Social Services. The *State Plan for Medical Assistance* for administering the Medicaid Program was developed under the guidance of the Advisory Committee on Medicare and Medicaid appointed by the Governor of the Commonwealth of Virginia. The State Plan is maintained through continued guidance from the Board of Medical Assistance Services, which approves amendments to the *State Plan for Medical Assistance* with policy support from the Governor's Advisory Committee on Medicare and Medicaid. Members of the Governor's Advisory Committee and the Board of Medical Assistance Services are appointed by the Governor.

Individuals originally became eligible for Medicaid because of their "categorical" relationship to two federal cash assistance programs: Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI). However, congressional mandates in the late 1980s resulted in dramatic changes in Medicaid eligibility provisions. Now individuals, in additional selected low-income groups, are eligible for Medicaid solely on the relationship of their incomes to the Federal Poverty Guidelines. New Federal Poverty Guidelines are published annually in the *Federal Register* and become effective upon publication.

On June 7, 2018, Governor Northam approved the state budget that expanded eligibility to include the Modified Adjusted Gross Income (MAGI) adult group, also known as the Medicaid Expansion covered group. The MAGI adult group includes adults between the ages of 19 and 64, who are not eligible for or enrolled in Medicare, and who meet income eligibility rules. After receiving the necessary approvals from the Centers for Medicare and Medicaid Services (CMS), DMAS began enrolling individuals in the MAGI adult group on January 1, 2019.

Medicaid is a means-tested program. Applicants' income and other resources must be within program financial standards, and different standards apply to different population groups, with children and pregnant women, the MAGI adult group, and persons who are aged, blind, or disabled. Reference Chapter III of this manual for detailed information on groups eligible for Medicaid.

General Scope of the Program

The Medical Assistance Program (Medicaid) is designed to assist eligible members in securing medical care within the guidelines of specified State and federal regulations. Medicaid provides access to medically necessary services or procedures for eligible members. The determination of medical necessity may be made by the Utilization Review Committee in certain facilities, a peer review organization, DMAS professional staff or DMAS contractors.

Covered Services

The following services are provided, **with limitations** (certain of these limitations are set forth below), by the Virginia Medicaid Program:

- BabyCare - Prenatal group patient education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants up to age two.

- Blood glucose monitors and test strips for pregnant women

- Case management services for high-risk pregnant women and children up to age 1

(as defined in the State Plan and subject to certain limitations)

- Christian Science sanatoria services
- Clinical psychology services
- Clinic services
- Community developmental disability services
- Contraceptive supplies, drugs and devices
- Dental services
- Diabetic test strips
- Durable medical equipment and supplies
- Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) – For individuals under age 21, EPSDT must include the services listed below:
- Screening services, which encompass all of the following services:
    - Comprehensive health and developmental history
    - Comprehensive, unclothed physical exam
    - Appropriate immunizations according to age and health history
    - Laboratory tests (including blood lead screening)

    - Health education

- Home health services

- Eyeglasses for all members younger than 21 years of age according to medical necessity

- Hearing services

- Inpatient psychiatric services for members under age 21

- Environmental investigations to determine the source of lead contamination for children with elevated blood lead levels

- Other medically necessary diagnostic and treatment services identified in an EPSDT screening exam, not limited to those covered services included above

- Skilled nursing facilities for persons under 21 years of age

- Transplant procedures as defined in the section “transplant services”

- All states are required to offer EPSDT to all Medicaid-eligible individuals under age 21 to determine any physical and mental defects that they may have and to provide health care, treatment, and other measures to correct or ameliorate the defects or chronic conditions discovered. The services available under EPSDT are not limited to those available in the Medicaid State Plan for Medical Assistance. Services requiring preauthorization under the State Plan for Medical Assistance will continue to require pre-authorization. DMAS reserves the right to utilize medical necessity

criteria for non-State Plan services under EPSDT.

- Commonwealth Coordinated Care Plus (CCC Plus) Waiver services - Individuals who meet the criteria for a nursing facility level of care can be authorized to receive adult day health care, personal care (agency directed or consumer directed) services, Respite Care and Skilled Respite Care services, Personal Emergency Response

System (PERS), Services Facilitation services, Transition Coordination, and Transition services

- Emergency hospital services

- Emergency services for aliens

- Enteral nutrition (EN) - Coverage is limited to circumstances in which the nutritional supplement is the sole source of nutrition except for individuals authorized through the CCC Plus Waiver or through EPSDT, is administered orally or through a nasogastric or gastrostomy tube, and is necessary to treat a medical condition. Coverage of oral administration does NOT include the provision of routine infant formula.

- Extended services for pregnant women, pregnancy-related and postpartum services for 60 days after the pregnancy ends (limitations applicable to all covered services apply to this group as to all other member groups)

- Eye refractions

- Plan First (family planning services) – Medicaid fee-for-service program for men and women who meet the eligibility criteria. Plan First includes coverage of those services necessary to prevent or delay a pregnancy. It shall not include services to

promote pregnancy such as infertility treatments. Family planning does not include counseling about, recommendations for or performance of abortions, or hysterectomies or procedures performed for medical reasons such as removal of intrauterine devices due to infections.

- Federally Qualified Health Center services
- Home and Community-Based Care Waiver services
- Home health services
- Hospice services for individuals certified as terminally ill (defined as having a medical prognosis that life expectancy is six months or less)
- Family and Individual Support Waiver
- Gender dysphoria treatment services
- Inpatient care hospital services
- Inpatient Psychiatric Hospital Services for Individuals under 21 years of age (medically needy are not covered)
- Intensive rehabilitation services
- Intermediate care facility – Individuals with Intellectual Disabilities Services (medically needy members are not covered)

- Laboratory and radiograph services

- Legend and Non-legend drugs are covered with some limitations or exclusions. (See the Pharmacy Manual for specific limitations and requirements)

- Mental health, with limitations, covered under mental health and intellectual disability community services listed below:

- Mental Health:

- Crisis stabilization
- Mental health support
- Assertive community treatment
- Intensive in-home services for children and adolescents
- Therapeutic day treatment for children and adolescents
- Partial hospitalization Program
- Intensive Outpatient Program
- Psychosocial rehabilitation
- Crisis intervention
- Case management

- Substance Use Disorder:

- Residential treatment for pregnant and postpartum women
- Day treatment for pregnant and postpartum women
- Crisis Intervention
- Intensive Outpatient
- Day Treatment
- Case Management
- Opioid Treatment

- Outpatient Treatment

- Community Living Waiver:

- Nurse-midwife services
- Nursing facility services

- Occupational therapy

- "Organ and disease" panel test procedures for blood chemistry tests

- Optometry services

- Outpatient hospital services

- Over-the-counter alternatives to certain classes of legend drugs. Upon a doctor's prescription or order, a pharmacy may provide and Medicaid will cover a drug that no longer requires a prescription to dispense. See the Pharmacy Manual for specific limitations and requirements.

- Papanicolaou smear (Pap) test

- Payment of deductible and coinsurance up to the Medicaid limit less any applicable payments for health care benefits paid in part by Title XVIII (Medicare) for services covered by Medicaid.
- Physician services

- Podiatry services

- Prostate specific antigen (PSA) test (1998)

- Prostheses limited to artificial arms, legs, and the items necessary for attaching the prostheses, which must be pre-authorized by the DMAS central office. Also breast prostheses for any medically necessary reason and ocular prostheses for reason for loss of eyeball regardless of age of the member or the cause of the loss of the eyeball.

- Psychiatric Hospitals for the Aged (65 Years and Older)

- Psychological testing for persons with intellectual disability as part of the evaluation prior to admission to a nursing facility (January 1, 1989)

- Reconstructive surgery - post-mastectomy (1998)

- Rehabilitation services (physical therapy – effective 1969; other rehabilitation services – effective 1986)

- Renal dialysis clinic services

- Routine preventive medical and dental exams and immunizations, sensory and developmental screenings and immunizations are covered for all eligible members under the age of 21

- Routine preventive and wellness services, including annual wellness exams, immunizations, smoking cessation, and nutritional counseling services for the MAGI

Adult (Medicaid Expansion) covered group.

- Rural Health Clinic services
- School-based services
- Services for individuals age 65 and older in institutions for mental diseases
- Specialized nursing facility services
- Speech-language therapy services
- CCC Plus Waiver services - For children and adults who are chronically ill or severely impaired, needing both a medical device to compensate for the loss of a vital body function and require substantial and ongoing skilled nursing care to avert further disability or to sustain their lives. Authorized services include Private Duty Nursing, Private Duty Respite Care services, Personal Care (Adults Only), Assistive Technology, Environmental Modifications and Transition services.
- Telemedicine for selected services.
- Tobacco Cessation screening, counseling and pharmacotherapies.
- Transplant services: kidney and corneal transplants, heart, lung, and liver transplants, without age limits; under EPSDT, liver, heart, lung, small bowel and bone marrow transplants and any other medically necessary transplant procedures that are not experimental or investigational, limited to persons under 21 years of age. Coverage of bone marrow transplants for individuals over 21 years of age is

allowed for a diagnosis of lymphoma or breast cancer, leukemia, or myeloma.

- Transportation services related to medical care

- Treatment Foster Care Case Management

General Exclusions

Payment cannot be made under the Medicaid Program for certain items and services, and Virginia Medicaid will not reimburse providers for these non-covered services. Members have been advised that they may be responsible for payment to providers for non-covered services. Prior to the provision of the service, the provider must advise the member that he or she may be billed for the non-covered service. The provider may not bill the member for missed or broken appointments, which includes transportation services arranged by the member who is not at the pickup point or declines to get into the vehicle when the provider arrives.

Examples of such non-covered services are as follows:

- Abortions, except when the life or health of the mother is substantially endangered

- Acupuncture

- Artificial insemination or in vitro fertilization

- Autopsy examinations

- Cosmetic surgery

- Courtesy calls - visits in which no identifiable medical service was rendered
- Custodial care
- DESI drugs (drugs considered to be less than effective by the Food and Drug Administration)
- Domestic services (except for those approved as part of personal care services or homemaker services under BabyCare or EPSDT)
- Experimental medical or surgical procedures
- Eyeglass services for members age 21 and over
- Fertility Services - Services to promote fertility are not covered. However, if there is a disease of the reproductive system that requires treatment to maintain overall health, the medical procedure will be covered
- Free services - Services provided free to the general public cannot be billed to Medicaid; this exclusion does not apply where items and services are furnished to an indigent individual without charge because of his or her inability to pay, provided the provider, physician, or supplier bills other patients to the extent that they are able to pay
- Items or services covered under a workers' compensation law or other payment sources
- Meals-on-Wheels or similar food service arrangements and domestic housekeeping

services which are unrelated to patient care

- Medical care provided by mail or telephone (not including telemedicine)
- Medical care provided in freestanding psychiatric hospitals except through EPSDT and SUD waiver, or for individuals aged 65 and over
- Personal comfort items
- Physician hospital services for non-covered hospital stays
- Private duty nursing services – Other than for children under an appropriate waiver or EPSDT and adults under the appropriate waiver
- Procedures prohibited by State or federal statute or regulations
- Prostheses (other than limbs, and the items necessary for attaching them, and breast prostheses)
- Psychological testing done for purposes of educational diagnosis or school admission or placement
- Routine foot care
- Screening services: Exceptions: Pap smears, mammograms, and PSA tests consistent with the guidelines published by the American Cancer Society.

- Services determined not to be reasonable and/or medically necessary

- Services to persons age 21 to 65 in mental hospitals
- Sterilizations when the patient is under age 21 or legally incompetent

- Supplies and equipment for personal comfort, such as adult diapers except when provided as durable medical equipment, "Lifecall" systems (except under the EDCD, DD, and Intellectual Disability Waivers), and air cleaners

- Unkept or broken appointments

- Unoccupied nursing facility beds except for therapeutic leave days for nursing facility patients

- Weight loss programs

MEMBER COPAYS

COPAYS ARE THE SAME FOR CATEGORICALLY NEEDY MEMBERS, QUALIFIED MEDICARE BENEFICIARIES (QMBS), AND MEDICALLY NEEDY MEMBERS. COPAYS AND THEIR AMOUNTS ARE EXPLAINED IN CHAPTER III OF THIS MANUAL.

Managed Care Programs

Coverage for the vast majority of Medicaid enrolled individuals is provided through one of the DMAS managed care programs, Medallion 4.0 or Commonwealth Coordinated Care Plus (CCC Plus). Medallion 4.0 and CCC Plus programs contract with the same six managed care organizations (MCOs), and all MCOs offer coverage statewide. In addition, both CCC Plus and Medallion 4.0 provide services that help keep people healthy as well as services that focus on improving health outcomes. For more information on the current health plans, please visit www.dmas.virginia.gov.

Medallion 4.0 serves as the delivery system for children, pregnant women, and individuals in

the MAGI Adult Group who are not determined to be "medically complex." CCC Plus provides a higher acuity of care coordination services and serves as the delivery system that provides coverage for individuals who are aged, blind or disabled, or who are dually eligible for Medicare and Medicaid, or who receive long-term services and supports, or individuals in the MAGI adult group determined to be "medically complex." "Medically complex" is defined as individuals who have complex medical and/or behavioral health condition and a functional impairment, or an intellectual or developmental disability.

Individuals awaiting managed care enrollment will receive coverage through the DMAS feefor-service program for a brief period (approximately 15-45 days) until they are enrolled in managed care. Additionally, some services for managed care enrolled individuals are covered through fee-for-service; these are referred to as managed care carved-out services. Detailed information about managed care-excluded populations and carved out services for Medallion 4.0 and CCC Plus is available on the DMAS website at http://www.dmas.virginia.gov, under Managed Care Benefits.

Once enrolled in managed care, members have up to 90 days to change their plan for any reason. Members also have the ability to change their plan during their annual open enrollment period. Open enrollment varies by population and program. For the MAGI Adult (expansion) population, open enrollment is from November 1 through December 31 each year. For CCC Plus, open enrollment is from October 1through December 18 each year. For Medallion 4.0 open enrollment varies by program region. (See Managed Care Enrollment Broker section below for additional information.)

Managed Care Enrollment Broker (Maximus)

DMAS contracts with an enrollment broker, Maximus, which provides information to help Medallion and CCC Plus members select or change health plans. Members can find out which health plans contract with their primary care provider (PCP) or other provider. Providers should also let their members know which Medicaid health plans they accept. Members may use the following Maximus contact information for the Medallion 4.0 and CCC Plus managed care programs.

- **Medallion 4.0**

  Maximus has designed a mobile app for managed care enrollment for the Medallion 4.0 program. The app is available to download in the Apple App Store and Google Play for both iPhone and Android users.

  To get the free mobile app, search for Virginia Managed Care on the Apple App Store

or Google Play and download. After downloading the app, members will log in using a two-step identification process, Medicaid ID, and social security number, or social security number and date of birth; non-members can log-in as guests.

Similar to the website, the main capabilities of the app allow members to view their profile, compare health plans, enroll in a health plan, change health plans, and search for providers and health plan information. For more information, members can also visit the Medallion 4.0 enrollment website at: https://virginiamanagedcare.com/ or call 1-800-643-2273 or TTY: 1-800-817-6608.

- **CCC Plus**

  Members can visit the enrollment website for the CCC Plus managed care program at https://cccplusva.com/ to view the health plan comparison chart and to choose or change their health plan. Members can also call the CCC Plus Helpline at 1-834374-9159 or TTY 1-800-817-6608 for more information.

MCO Provider Reimbursement

In order to be reimbursed for services provided to a managed care enrolled individual, providers must follow their respective contract with the managed care plan. The managed care plan may utilize different prior authorization, billing, and reimbursement guidelines than those described for Medicaid fee-for service individuals. For more information, please contact the individual 's managed care plan directly. Providers interested in contracting with the plans should also contact the MCO directly. MCO contact information for contracting and credentialing is available on the DMAS website:

- **Medallion 4.0** The managed care helpline for the Medallion program is 800-6432273 and the web address is https://www.virginiamanagedcare.com/
- **CCC Plus** (http://www.dmas.virginia.gov/#/cccplusinformation See “Medical Provider Update October 2017”)

DMAS reimburses the health plans a monthly capitated fee for each member. These fees are preset, and are determined by demographics such as patient’s age, sex, program designation, and locality of residence. Each MCO is responsible for developing its own network of providers and for ensuring that its delivery system has an adequate number of facilities, locations, and personnel available and accessible to provide covered services for its members. Providers who contract with a MCO must meet the MCO’s contracting requirements.

Medicaid-contracted MCOs must provide all the services covered by Medicaid, at least within an equal, amount, duration, and scope as Medicaid, except for certain "carved-out services." "Carved-out" means that the client remains enrolled in the MCO plan but the carved-out services are covered and reimbursed by DMAS within DMAS program guidelines. **DMAS will NOT provide reimbursement for services provided to MCO enrolled members EXCEPT for those services carved-out specifically from the MCO contracts.** Carved-out services vary by program and are listed in the CCC Plus and Medallion 4.0 Contracts, available on the DMAS Website, in the Managed Care Benefits section. The member must present his or her Medicaid plastic ID card when receiving carved-out services.

Eligibility and MCO Enrollment Verification

Medicaid eligibility and managed care enrollment coverage must be verified before treatment is provided. Medallion and CCC Plus members will have a MCO identification card and a Medicaid card. Medallion and CCC Plus MCO providers must adhere to their contract with the MCO regarding referrals, prior authorization, and billing requirements. Service authorization from the member's MCO is required for any out-of-network services, *except for emergency and family planning services.* The provider is responsible for ensuring that proper referrals and service authorizations are obtained. If the MCO denies authorization for a service, the member may exercise his right to appeal to the MCO. Members can also appeal to DMAS after first exhausting the MCO's appeal process. A provider may bill a member only when the provider has provided advanced written notice to the member, prior to rendering services that their MCO/Medicaid will not pay for the service. The notice must also share that the provider is accepting the member as a private pay patient, not as a Medicaid patient and the services being provided are the financial responsibility of the patient. Failure to confirm Medicaid eligibility and MCO coverage can result in a denial of payment.

To verify eligibility, call the MCO's enrollment verification system or the DMAS MediCall line at 1-800-772-9996 or 1-800-884-9730 (outside of Richmond), or (804) 965-9732 or (804) 965-9733 for Richmond and the surrounding counties. Eligibility information is also available using the web-based Automated Response System (ARS). When using the DMAS MediCall line or the ARS system, MCO information, if applicable, follows Medicaid eligibility information.

Continuity of Care

The Department attempts to make the transition between fee-for-service Medicaid and the MCO seamless whenever possible. As a result there is a process to ensure that the Medicaid information and authorization information is transferred and honored. In order to assure continuity of care for members enrolled in MCOs, the following procedures are used:

- The Member's MCO shall assume responsibility for all managed care contract covered services authorized by either the Department or a previous MCO, which are rendered after the MCO enrollment effective date, in the absence of a written agreement otherwise. For on-going services, such as home health, outpatient mental health, and outpatient rehabilitation therapies, etc., the member's MCO shall continue authorized services without interruption until the Contractor completes its utilization review process to determine medical necessity of continued services or to transition services to a network provider;
- DMAS shall assume responsibility for all covered services authorized by the member's previous MCO which are rendered after the effective date of dis-enrollment to the feefor-service system, if the member otherwise remains eligible for the service(s), and if the provider is a Medicaid provider;
- If the prior authorized service is an inpatient stay, the claim should be handled as follows: o If the provider contracts with the MCO under a per diem payment methodology, the financial responsibility shall be allocated between the member's current MCO and either DMAS or the new MCO. In the absence

  of a written agreement otherwise, the member's current MCO and DMAS or the new MCO shall each pay for the period during which the member is enrolled with the entity.

  o If the provider contracts with the MCO under a DRG payment methodology, the MCO is responsible for the full inpatient hospitalization from admission to discharge, including any outlier charges.

- If services have been authorized using a provider who is out of network, the member's MCO may elect to reauthorize (but not deny) those services using an in-network provider.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children's Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the

provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia's Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia's children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;

  - Assistive technology

  - Blood lead testing

- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:

  - Intensive in-home services

  - Therapeutic day treatment

- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations

- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)
- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a

physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)
- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

EMERGENCY MEDICAID SERVICES FOR ALIENS

Section 1903v of the Social Security Act (42 U.S.C. 1396b) requires Medicaid to cover emergency services for specified aliens when these services are provided in a hospital emergency room or inpatient hospital setting. (See Chapter III for details on eligibility.)

The medical conditions subject to this coverage may include, but are not limited to, the following:

- Cerebral vascular attacks
- Traumatic injuries
- Childbirth
- Acute coronary difficulties
- Emergency surgeries (i.e., appendectomies)
- Episodes of acute pain (etiology unknown)
- Acute infectious processes requiring intravenous antibiotics
- Fractures

To be covered, the services must meet emergency treatment criteria and are limited to:

- Emergency room care
- Physician services
- Inpatient hospitalization not to exceed limits established for other Medicaid members
- Ambulance service to the emergency room or hospital
- Inpatient and outpatient pharmacy services related to the emergency treatment

Hospital outpatient follow-up visits or physician office visits related to the emergency care are not included in the covered services.

Client Medical Management (CMM)

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 431.54(e-f) and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC

30-130-820. (See the “Exhibits” section at the end of this chapter for detailed information on the CMM Program.)

Providers may refer Medicaid patients suspected of inappropriately using or abusing

Medicaid services to DMAS's Recipient Monitoring Unit. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician and/or pharmacy in the Client Medical Management Program.

Referrals may be made by telephone or in writing. The number for the Recipient Monitoring

Unit is (804) 786-6548 or toll-free (888) 323-0589. Referrals can also be faxed to (804) 3718891. Office hours are 8:15 a.m. – 5:00 p.m., Monday through Friday except state holidays. Voice mail receives after-hours referrals.

Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

When making a referral, provide the member's name and Medicaid number and a brief statement regarding the nature of the utilization problems. Copies of pertinent documentation, such as emergency records, would be helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

Sources of Information

MediCall Automated Voice Response System

Toll-free numbers are available 24-hours-per-day, seven days a week, to confirm member

eligibility status, claim status and check status. The numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

Providers access the system using their Virginia Medicaid provider number as identification. Specific instructions on the use of the verification systems are included in “Exhibits” at the end of this chapter.

Automated Response System (ARS)

Providers may use the Internet to verify member eligibility and perform other inquiry functions. Inquiries can be submitted in real-time. Specific instructions on the use of the ARS are included in “Exhibits” at the end of this chapter.

HELPLINE

A toll-free "HELPLINE" is available to assist providers in interpreting Medicaid policy and procedures and in resolving problems with individual claims. The HELPLINE numbers are:

- (804)786-6273 Richmond Area & out-of-state long distance
- 1-800-552-8627 In-state long distance (toll free)

The HELPLINE is available Monday through Friday from 8:00 a.m. to 5:00 p.m., except on holidays.

The Virginia Medicaid provider number must accompany all provider inquiries (both written and via the HELPLINE). All provider information and data are filed by provider number. This number will expedite recovery of the requested information.

Do not use these HELPLINE numbers for member eligibility verification and eligibility questions. Local departments of social services are responsible for supplying information to members, and members who have questions about the Medicaid Program should be directed to their local departments of social services. If MediCall is not available, the data will also be unavailable to the HELPLINE (when the system is down).

The Medicaid HELPLINE and MediCall numbers are for provider use only and should not be given to members.

ELECTRONIC FILING REQUIREMENTS

The Virginia MMIS is HIPAA-compliant and, therefore, supports all electronic filing requirements and code sets mandated by the legislation.

The Virginia MMIS will accommodate the following Electronic Data Interchange (EDI) transactions according to the specifications published in the ASC X12 Implementation Guides version 4010A1.

- 837P for submission of professional claims
- 837I for submission of institutional claims
- 837D for submission of dental claims
- 276 & 277 for claims status inquiry and response
- 835 for remittance advice information for adjudicated (paid and denied) 270 & 271 for eligibility inquiry and response
- 278 for prior authorization request and response.

Although not mandated by HIPAA, DMAS has opted to produce an unsolicited 277 transaction to report information on pended claims.

If you are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov/wps/portal.

Provider Manual Updates

This manual is designed to accommodate new pages as further interpretations of the law and changes in policy and procedures are made. Accordingly, revised pages or sections will be issued by the Department of Medical Assistance Services (DMAS) as needed.

Notice of Provider Responsibility

The provider is responsible for reading and adhering to the policies and regulations explained in this manual and for ensuring that all employees do likewise. The provider also certifies by his or her personal signature or the signature of an authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Satisfaction and payment of any claim will be from federal and State funds, and any provider who submits false claims, statements, or documents may be prosecuted under applicable federal or State laws.

THE VIRGINIA MEDICAL ASSISTANCE MEDICALL SYSTEM

GENERAL INFORMATION

The Virginia Medical Assistance MediCall System offers Medicaid providers twenty-four hour-a-day, seven-day-a-week access to current member eligibility information, check status, claims status, prior authorization information, service limit information, pharmacy prescriber identification number cross reference, and information to access member eligibility and provider payment verification via the Internet. MediCall is an enhancement to the previous Medicaid Audio Verification Response System (AVRS).

Not only does MediCall offer providers flexibility in choosing the time of day for their inquiries, but it also makes efficient use of staff time. A valid provider number and a touchtone telephone are required to access MediCall.

To reach an operator while using the member eligibility verification feature of MediCall, key

“0” at any prompt within the Member Eligibility menu. Operator assisted calls are limited to three name searches per call. The operator will not be able to return the caller to MediCall for further inquiries. Operators are available from 8:30 a.m. to 4:30 p.m. Eastern time, Monday through Friday except for state holidays.

MediCall prompts the caller throughout the inquiry, giving and receiving only essential,

pertinent information. The data provided is the most up-to-date information available, direct from the Medicaid eligibility, claims and remittance databases. If the caller waits too long to respond to a system prompt, the call will be disconnected.

System downtime will be scheduled during non-peak hours. If the caller dials MediCall during this time, the caller will be informed that the system is unavailable. System downtime is typically scheduled for:

2:00 a.m. to 4:00 a.m. Daily 2:00 a.m. to 6:30 a.m. Thursday

10:00 p.m. Saturday to 6:00 a.m. Sunday

The telephone numbers are:

1-800-772-9996	Toll-free throughout the United States
1-800-884-9730	Toll-free throughout the United States
(804) 965-9732	Richmond and Surrounding Counties
(804) 965-9733	Richmond and Surrounding Counties

If you have any questions regarding the use of MediCall, contact the Medicaid Provider "HELPLINE." The HELPLINE is available Monday through Friday from 8:30 a.m. to 4:30 p.m., except State holidays, to answer questions. The HELPLINE numbers are:

1-804-786-6273 Richmond Area and out of state long distance

In state long distance (toll-free) 1-800-552-8627

HOW TO USE THE SYSTEM

To access MediCall, the provider must have a currently active Medicaid provider number. The provider's number is verified before access to MediCall is authorized.

Responses by the caller to MediCall are required within a specified period of time. If the time limit is exceeded, the call will be disconnected. The caller should have the following information available before calling:

- 10 digit National Provider Identifier (NPI) or Atypical Provider Identifier (API)
- Member Medicaid Number (12 digits) or Social Security Number (9 digits) **and**

  Date of Birth (8 digits) in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status)
- From and Thru Date(s) of Service in month, day, century and year format (mmddyyyy) (necessary for member eligibility verification and claims status). The caller will have the following limits when entering dates of service:
- The caller does not have to enter a **Thru** date of service if services were rendered on a single day. Pressing the # key prompts the system to continue.
- Future month information is only available in the last week of the current month.
- Inquiries cannot be on dates of service more than one year prior to the date of inquiry.

After dialing the MediCall number, the system will ask for the NPI or API. Enter the 10 digit number and select from the following options:

- Press “1” for member eligibility verification.

- Press “2” for claims status.
- Press “3” for recent check amounts.
- Press “4” for service authorization information.
- Press “5” for service limit information.

MEMBER ELIGIBILITY VERIFICATION

Enter the From and Thru dates of service. **The service dates for member eligibility verification cannot span more than 31 days.** When the dates of service have been entered, MediCall will verify the information and respond by speaking the first six letters of the last name and the member's Medicaid number for confirmation.

Remain on the line to obtain important member information that might affect payment, such as:

- Special Indicator Codes (Copayment)
- Client Medical Management Information Including Pharmacy/Physician Telephone Number
- Medicare Eligibility
- Other Insurance Coverage

- Special Coverage (QMB, QMB--Extended)
- "MEDALLION" Participation (prior to July, 2012)
- Managed Care Organization provider name and assignment dates

At this point, MediCall will prompt the caller for the next action. The caller may ask for additional dates of service on this member, or may inquire on another member.

The caller may check up to **three** dates of service for each member and inquire on up to **three** members per call.

If the caller is using a Social Security Number instead of the member ID number, the dates of service will relate to the first member ID reported. If multiple open records exist for the same Social Security Number, you will be advised to contact the local department of social services. You will be given a 3-digit city/county code of the appropriate agency and a 5-digit caseworker code. A cross-reference list of the city/county codes is provided as an exhibit to this chapter.

The caller will receive a "not eligible" response if the future dates about which he or she inquires are beyond the information on file.

A response, "not eligible," will be given if the member is not eligible for all days within the time span entered.

PROVIDER CHECK LOG

The most recent check information is presented by invoice type. This inquiry permits the provider to receive check dates and amounts from the most recent three remittances.

CLAIMS STATUS

For claims status information, the MediCall system will prompt the provider to choose the among the following invoice types (additional information in italics).

- For inpatient care, press 01.
- For long-term care, press 02.
- For outpatient hospital, home health or rehabilitation services, press 03.
- For personal care, press 04.
- For practitioner (physician CMS-1500 billing), press 05.
- For pharmacy, press 06.
- For independent labs (outpatient lab services), press 08.
- For Medicare crossover, press 09.
- For dental, press 11.
- For transportation, press 13.

For claims status, the From date cannot be more than 365 days in the past. The Thru date cannot be more than 31 days later than the From date. After keying the member identification number and the From and Thru date(s) of service, MediCall will provide the status of each claim up to and including five claims. MediCall will prompt for any additional claims or return to the main menu.

SERVICE AUTHORIZATION INFORMATION

The From and Thru dates for prior authorization cannot span more than 365 days. When the 12-digit member ID number and the 8-digit from and through dates of service have been entered, you will be prompted to enter the 11-digit prior authorization number, if known. If you do not know the prior authorization number, then press the pound (#) key. MediCall will verify prior authorization data on file. The system will prompt you to return additional prior authorization data for the same member and dates, enter new dates for the same member, another prior authorization number for the same member or to enter another member ID number to begin a new inquiry.

SERVICE LIMITS INFORMATION

Service limits can be obtained by service type or procedure code:

- For occupational therapy, press 1. For physical therapy, press 2 For speech therapy, press 3.
- For home health aide, press 4.
- For home health skilled nursing, press 5.
- For DME purchases, press 6 and for DME rentals, press 7.

For occupational therapy, speech therapy or physical therapy the MediCall system will return non-school based and school based service limits separately.

PRESCRIBING PROVIDER ID

Only enrolled Pharmacy providers can access this choice. When prompted, the caller should enter the license number of the prescriber. MediCall will return the first six letters of the prescriber’s last name and Medical Assistance provider number. If the prescriber is not

active in Virginia Medicaid, you will receive a message that the number is not on file.

The Automated Response System (ARS)

GENERAL INFORMATION

The Automated Response System (ARS) offers Medicaid and FAMIS providers twenty-fourhour-a-day, seven-day-a week Internet access to current member eligibility information, service limits, claim status, service authorizations, and provider payment history. This weenabled tool helps provide cost-effective care for members, and allows providers to access current information quickly and conveniently.

The ARS can be accessed through the Virginia Medicaid Web portal at www.virginiamedicaid.dmas.virginia.gov. Please visit the portal for information on registration and use of the ARS.

CITY/COUNTY CODES

(The Three-Digit Numerical Identifier of the Local Social Services/Welfare Agency Currently Handling the Case)

If two or more member records using the same SSN are active on the same date of service, inquirers are prompted to contact the Social Services agency for resolution.

COUNTIES

001	Accomack	049	Cumberland	097	King and Queen
003	Albermarle	051	Dickenson	099	King George
005	Alleghany	053	Dinwiddie	101	King William
007	Amelia	057	Essex	103	Lancaster
009	Amherst	059	Fairfax	105	Lee
011	Appomattox	061	Fauquier	107	Loudoun
013	Arlington	063	Floyd	109	Louisa
015	Augusta	065	Fluvanna	111	Luneburg
017	Bath	067	Franklin	113	Madison
019	Bedford	069	Frederick	115	Mathews
021	Bland	071	Giles	117	Mecklenburg

023	Botetourt	073	Gloucester	119	Middlesex
025	Brunswick	075	Goochland	121	Montgomery
027	Buchanan	077	Grayson	125	Nelson
029	Buckingham	079	Greene	127	New Kent
031	Campbell	081	Greensville	131	Northampton
033	Caroline	083	Halifax	135	Nottoway
035	Carroll	085	Hanover	137	Orange
037	Charlotte	087	Henrico	139	Page
041	Chesterfield	089	Henry	141	Patrick
043	Clarke	091	Highland	143	Pittsylvania
045	Craig	093	Isle of Wight	145	Powhatan
047	Culpeper	095	James City	147	Prince Edward
149	Prince George	167	Russell	179	Stafford
153	Prince William	169	Scott	181	Surry
155	Pulaski	171	Shenandoah	183	Sussex
157	Rappahannock	173	Smyth	185	Tazewell
159	Richmond	175	Southampton	187	Warren
161	Roanoke	177	Spotsylvania	191	Washington
193	Westmoreland	195	Wise	197	Wythe
199	York				

CITIES

510	Alexandria	620	Franklin	710	Norfolk
515	Bedford	630	Fredericksburg	720	Norton
520	Bristol	640	Galax	730	Petersburg
530	Buena Vista	650	Hampton	735	Poquoson
540	Charlottesville	660	Harrisonburg	740	Portsmouth
550	Chesapeake	670	Hopewell	750	Radford
570	Colonial Heights	678	Lexington	760	Richmond
580	Covington	680	Lynchburg	770	Roanoke
590	Danville	683	Manassas	775	Salem
595	Emporia	685	Manassas Park	780	South Boston
600	Fairfax	690	Martinsville	790	Staunton
610	Falls Church	700	Newport News	800	Suffolk
810	Virginia Beach	820	Waynesboro	830	Williamsburg
840	Winchester				

976 Central Processing Unit for FAMIS

STATE MENTAL HEALTH FACILITIES

983 Southern Virginia Mental Health Institute

985. Southeastern State Hospital
986. Northern Virginia Training Center
987. Virginia Treatment Center
988. Northern Virginia Mental Health Institute

990. Central Virginia Training Center
991. Western State Hospital
992. Southwestern State Hospital
993. Piedmont State Hospital
994. Eastern State Hospital

996. Hiram Davis Hospital
997. Catawba State Hospital

CLIENT MEDICAL MANAGEMENT INTRODUCTION

The Client Medical Management Program (CMM) for members and providers is a utilization control and case management program designed to promote proper medical management of essential health care and, at the same time, promote cost efficiency. The basis for CMM member and provider restriction procedures is established through federal regulations in 42 CFR 456.3 and state regulations as set forth in 12 VAC 30-130-800 through 12 VAC 30130-810.

MEMBER RESTRICTION

Utilization Review and Case Management

Federal regulations allow states to restrict members to designated providers when the members have utilized services at a frequency or amount that is not medically necessary.

Restricted members are identified and managed by the Recipient Monitoring Unit (RMU) in the Division of Program Integrity.

CMM enrollment is based upon review of the individual member's utilization patterns. All Medicaid members except MCO members and institutionalized long-term care residents are eligible for utilization review by RMU staff. If the member's utilization patterns meet the criteria for enrollment in CMM, the member is notified to select designated primary providers. Examples of inappropriate utilization are:

- Emergency room use for medical problems that could be treated in a physician's office;
- Using more than one physician and/or pharmacy to receive the same or similar medical treatment or prescriptions; and
- A pattern of non-compliance which is inconsistent with sound fiscal or medical practices.

Each CMM member is assigned a case manager in the Recipient Monitoring Unit to assist both members and providers with problems and questions related to CMM. The case manager is available to:

- Resolve case problems related to CMM procedures and provider assignments;
- Counsel the member on the appropriate access to healthcare;
- Approve/deny requests for provider changes; and
- Complete a utilization review prior to the end of the enrollment period to determine if CMM restriction should be extended.

Member Enrollment Procedures

Members identified for CMM enrollment receive a letter explaining the member/provider relationships under medical management. The letter includes the Member/Primary Provider Agreement forms (see the sample forms at the end of this section) with directions for completing and returning the form to the Recipient Monitoring Unit. Members are given thirty (30) days to select their primary providers by obtaining their signatures on the form.

The provider's signature indicates agreement to participate as the CMM provider for the member. DMAS reviews member requests for specific providers for appropriateness and to ensure member accessibility to all required medical services.

Members also have thirty (30) days from the receipt of the restriction notice to appeal enrollment in CMM. Assignment to designated providers is not implemented during the appeal process.

CMM enrollment is for 24 months. Assignment to both a physician and pharmacy is made with few exceptions.

When members do not return choices to the Recipient Monitoring Unit or have difficulty in finding providers, RMU staff will select providers for them. RMU staff contact providers directly to request participation as a CMM provider for the member and follow-up by mailing or faxing the agreement form for the provider's signature.

When completed agreement forms are received, the member is enrolled in CMM effective the first of the next month in which a restricted Medicaid card can be generated. Both members and selected providers are notified by mail of the enrollment date.

Members enrolled in the Client Medical Management can be identified through the process of eligibility verification. A swipe of the Medicaid ID card will return the names and telephone numbers of the primary care physician and designated pharmacy. The dates of assignment to each provider are also included. This information is also available through the MediCall System and the web-based Automated Response System (ARS). Instructions for both resources are provided in this chapter.

Each CMM member also receives an individual Medicaid coverage letter with the name(s) and address of the designated primary health care provider and/or designated pharmacy printed on the front each time there is a change in providers.

Designated Primary Care Physicians (PCP)

Any physician enrolled in Medicaid as an individual practitioner may serve as a designated primary care physician (PCP) except when:

- The physician's practice is limited to the delivery of emergency room services; or
- The physician has been notified by DMAS that he or she may not serve as a designated provider, covering provider, or referral provider for restricted members.

Federally Qualified Community Health Centers (FQHCs) and Rural Health Clinics (RHCs) may serve as PCPs also. Other provider types such as ambulatory care centers may be established as designated providers as needed but only with the approval of DMAS.

Primary care physicians are responsible for coordinating routine medical care and making referrals to specialists as necessary. The PCP must arrange 24-hour coverage when they are not available and explain to their assigned members all procedures to follow when the office is closed or when there is an urgent or emergency situation.

The provider's *NPI number* is used for billing and referral purposes.

Designated Pharmacies

Any pharmacy enrolled as a community pharmacy billing on the Pharmacy Claim Form or other acceptable media may serve as a designated pharmacy unless the pharmacy has been notified by DMAS that it may not serve as a designated provider.

Designated pharmacies must monitor the member's drug regimen. The pharmacist should fill prescriptions from the PCP, referred physicians, and emergency prescriptions. Referrals can be confirmed by reviewing the member's copy of the referral form or by contacting the

PCP's office. Close coordination between the PCP and the pharmacist, particularly if a medication problem has been identified, is a very important component of the program.

Changing Designated CMM Providers

The member or designated provider may initiate a request for a change of a designated provider by contacting the Recipient Monitoring Unit. Designated providers requesting a change must notify the member in addition to contacting RMU. If the designated provider requests the change and the member does not select a new provider by the established deadline, RMU shall select for them.

All changes must be preauthorized by DMAS RMU staff. The member's RMU case manager may contact the provider before making a final decision on the change request to try to resolve questions or issues and avoid unnecessary changes. If DMAS denies a member's request, the member shall be notified in writing and given the right to appeal the decision. Changes are allowed for:

1. Relocation of the member or provider;
2. Inability of the designated provider to meet the routine medical/pharmaceutical needs of the member; or
3. Breakdown of the relationship between the provider and member.

Provider changes can occur any time of the month because the effective date is the date the new provider signs the Member/Primary Provider Agreement form. When a new provider is assigned, RMU mails a letter to the member confirming the effective date of the change. The letter instructs the member *to show the letter with the Medicaid identification card*. Letters go to the affected providers also. All verification inquiries will return the new primary provider from the date it is entered into the computer system.

A PCP No Longer in Practice

If a provider leaves the practice or retires, he or she must notify CMM so that the restricted member can be reassigned to a new PCP.

Covered Services and Limitations

Under CMM, DMAS will pay for covered outpatient medical and/or pharmaceutical services only when they are provided (1) by the designated providers, (2) by physicians seen on written referral from the PCP, (3) by covering providers linked with the designated provider in a CMM Affiliation Group, or (4) in a medical emergency. A medical emergency means that a delay in obtaining treatment may cause death or serious impairment of the health of the member. Payment for covered outpatient services will be denied in all other instances (unless the covered services are excluded from Client Medical Management Program requirements), and the member may be billed for the services.

All services should be coordinated with the designated provider. The CMM PCP referral does not override Medicaid service limitations. All DMAS requirements for reimbursement, such as pre-authorization, still apply as indicated in each provider manual.

Physician Services

A Medicaid-enrolled physician who is not the PCP may provide and be paid for outpatient services to these members only:

- In a medical emergency situation in which a delay in the treatment may cause death or result in lasting injury or harm to the member.

- On written referral from the PCP using the Practitioner Referral Form (DMAS-70). This also applies to covering physicians who have not been affiliated with the PCP.

- When they are a part of a CMM provider affiliation group that includes the PCP.

- For other services covered by DMAS which are excluded from the Client Medical Management Program requirements.

Services Excluded from PCP Referral

These services should be coordinated with the primary health care provider whose name appears on the member's eligibility card, but they are excluded from special billing instructions for the Client Medical Management Program.

Covered services that do not need a referral include:

- Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) wellchild exams and screenings (members under age 21);

- Immunizations (member under age 21);

- Family planning services;

- Expanded prenatal services, including prenatal group education, nutrition services, and homemaker services for pregnant women and care coordination for high-risk pregnant women and infants;

- Dental services (members under age 21);

- Services provided under Home and Community-Based Care Waivered Services;
- Hospice services;
- Renal dialysis services;
- Routine vision care services (routine diagnostic exams for members of all ages and eyeglasses for members under age 21). Medical treatment for diseases of the eye and its appendages still requires a written referral;
- Audiology services;
- Podiatry services;
- Prosthetic services;
- MH/ID community rehabilitative services;
- Psychiatric diagnostic and therapeutic services (limited sessions of outpatient treatment);
- Inpatient hospital services;
- Life-threatening medical emergencies; and

- School-based services.

CMM Provider Affiliation Groups

Physician affiliation groups allow covering physicians to see each other's patients without a written referral. CMM affiliations may be set up for physicians within a practice or for the single practitioner who arranges coverage by a physician not sharing office space. Affiliations can be open-ended or for a specified period of time (such as when the PCP is away from the office for days or weeks). CMM affiliations may include physicians, Rural Health Clinics, Federally Qualified Health Clinics (FQHC), and nurse practitioners.

Affiliations are not member-specific. This means that once provider numbers are affiliated, claims will pay for all CMM members who receive services from a member of an affiliation group that includes the member's PCP on the date of service.

The PCP requests affiliation by completing the CMM Provider Affiliation Form (see sample form at the end of this section) and returning it to the Recipient Monitoring Unit (RMU). The form is used to set up a new affiliation group or to update a group. Providers are responsible for notifying DMAS when a new provider joins the group or a provider leaves the group to ensure claims are processed correctly. Contact the Recipient Monitoring Unit at (804) 786-6548 in Richmond, or toll-free at 1-888-323-0589, to request a form.

Emergency Room Services

Outpatient hospital emergency room services for restricted members are limited to reimbursement for medical emergencies. Emergency hospital services means that the threat to the life or health of the member necessitates the use of the most accessible hospital facility available that is equipped to furnish the services. Reimbursement may be conditional upon the review of the emergency-related diagnosis or trauma ICD diagnosis codes and the necessary documentation supporting the need for emergency services. Additional guidelines for payment of medical services provided in the outpatient hospital emergency room setting are listed in Chapter IV "Covered Services" in this manual.

CMM clients must have a written PCP referral in order for non-emergency services provided in the emergency room to be reimbursed at an all-inclusive rate. The PCP must use the Practitioner Referral Form, DMAS-70. Payment will be denied without a referral unless there is a life-threatening emergency. Non-emergency services provided without a PCP referral become non-covered services, and the member is responsible for the full cost of the emergency room visit.

CMM also requires a PCP referral form for:

- Reimbursement to CONSULTING physicians who treat a CMM client in the emergency room setting, and
- Reimbursement for any follow-up outpatient or office consultations resulting from an ER visit.

Emergency Pharmacy Services

Prescriptions may be filled by a non-designated pharmacy only in emergency situations (e.g., insulin or cardiac medications) when the designated pharmacy is closed or the designated pharmacy does not stock or is unable to obtain the drug.

Provider Reimbursement and Billing Instructions

Management Fees

Each physician, FQHC, or Rural Health Clinic that serves as a CMM primary care provider (PCP) receives a monthly case management fee of $5.00 for each assigned CMM member. Payment is made through a monthly remittance process. PCPs receive a monthly report listing the CMM members assigned the previous month for whom payment is made.

PCP and Designated Pharmacy Providers

DMAS pays for services rendered to CMM members through the existing fee-for-service

methodology. Designated providers (PCP's and pharmacies) bill Medicaid in the usual manner, but non-designated providers who are not affiliated with the CMM provider must follow special billing instructions. Complete instructions for the CMS 1500 (08-05) and UB-04 billing invoices as well as Point-of-Sale (POS) billing can be found in the billing instruction chapter of this manual.

Affiliated Providers

Providers who are affiliated with a designated CMM provider in the Medicaid system bill Medicaid in the usual manner with no special billing instructions. Claims process with a look-up to the CMM Affiliation Groups in the system.

Referral Providers

To receive payment for their services, referral providers authorized by the client's PCP to provide treatment to that client must place the Provider Identification Number of the PCP in Locator 17a (1D qualifier followed by the API number) or 17b (National Provider Identifier number of referring physician – 17B requirement effective 5/23/08) of the CMS-1500 (0805) and attach the Practitioner Referral Form.

Physicians Billing Emergency Room Services

When billing for emergency room services on the CMS-1500, the attending physician bills evaluation and management services with CPT codes 99281-99285 and enters "Y" in Block 24-C. When the PCP has referred the client to the emergency room, place the PCP's NPI number in Block 17b on the CMS -1500 and attach the Practitioner Referral form.

Facilities Billing Emergency Room Services with a Referral

When billing for emergency room services on the on the UB-04 CMS 14-50, place the PCP's provider number in space 78, and attach the Practitioner Referral Form.

Non-designated Pharmacy Providers

When billing on the Pharmacy Claim Form or as a Point-Of-Sale (POS) provider, enter code

"03" in the "Level of Service" field to indicate emergency.

REFERRALS TO THE CLIENT MEDICAL MANAGEMENT PROGRAM

DMAS providers may refer Medicaid patients suspected of inappropriate use or abuse of Medicaid services to the Recipient Monitoring Unit (RMU) of the Department of Medical Assistance Services. Referred members will be reviewed by DMAS staff to determine if the utilization meets regulatory criteria for restriction to a primary physician or pharmacy in the Client Medical Management (CMM) Program. See "Exhibits" at the end of Chapter I for detailed information on the CMM Program. If CMM enrollment is not indicated, RMU staff may educate members on the appropriate use of medical services, particularly emergency room services.

Referrals may be made by telephone, FAX, or in writing. A toll-free helpline is available for callers outside the Richmond area. Voice mail receives after-hours referrals. Written referrals should be mailed to:

Lead Analyst, Recipient Monitoring Unit

Division of Program Integrity

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

Telephone: (804) 786-6548

CMM Helpline: 1-888-323-0589

When making a referral, provide the name and Medicaid number of the member and a brief statement about the nature of the utilization problems. Copies of pertinent documentation, such as emergency room records, are helpful when making written referrals. For a telephone referral, the provider should give his or her name and telephone number in case DMAS has questions regarding the referral.

PROVIDER RESTRICTION

Restricted providers are identified and managed by the DMAS Provider Review Unit. States may restrict providers from participation in the Medicaid Program when the provider has provided items or services at a frequency or amount not medically necessary or has provided items or services of a quality that does not meet professionally recognized standards of health care. State regulations allow DMAS to restrict providers' participation as designated providers, referral providers, or covering providers for CMM restricted members when a provider has billed services at a frequency or level exceeding that which is medically necessary or when a provider's license to practice has been revoked or suspended in Virginia by the appropriate licensing board.

Provider restriction is for 24 months. Providers may appeal any proposed restriction in accordance with the *Code of Virginia*, Section 2.2-4000 et seq., as discussed in the chapter containing utilization review and control information in this manual. Restriction is not implemented pending the result of a timely appeal request.

Provider Participation Requirements (LEA)

MANAGED CARE AND FEE FOR SERVICE DELIVERY SYSTEMS

Most of the services covered through Virginia’s Medicaid and FAMIS programs are furnished through DMAS’ contracted MCOs and their network of providers; however, there are exceptions. Covered services provided by Local Education Agency (LEA) providers to member students when authorized by the student’s Individualized Education Plan (IEP) are managed by DMAS Fee-for-Service (FFS) system, and those providers must follow DMAS

FFS policies and procedures as set out in the LEA Provider Manual.

LEA PARTICIPATING PROVIDER

For purposes of this manual, a “local education agency” (LEA) refers to a school division that operates local public primary and secondary schools in Virginia, as well as the Virginia School for the Deaf and Blind (VSDB). A participating LEA provider (also referred to as “LEA billing provider” or “billing provider”) is a local education agency that has a current, signed Business Associate Agreement on file with the Department of Medical Assistance Services (DMAS) and is enrolled with DMAS as a participating provider.

LEA providers must complete the Business Associate Agreement as required in 45 CFR § 160.103 of the Final HIPAA Privacy Rule. More information about the Business Associate Agreement may be found on the web at www.dmas.virginia.gov.

LEA PROVIDER ENROLLMENT

For purposes of the LEA Provider Manual, DMAS distinguishes the following terms used to describe those responsible for providing LEA services:

LEA provider	The LEA or school division. Also known as the billing provider or facility provider.	An LEA provider must enroll with DMAS in order to bill for services.
Ordering, referring or prescribing (ORP) provider	The ORP provider is a qualified provider that is allowed to refer for school-based services according to their licensed scope of practice and according to state law.	An ORP provider must enroll with DMAS and may or may not render direct services.

Qualified provider	A healthcare professional licensed in Virginia and acting within their licensed scope of practice according to state law.	Qualified providers that order or refer students for services must enroll with DMAS in order to also serve as an ORP provider for school-based services.
Service rendering provider	The LEA employed or contracted staff member rendering direct services to the student.	This includes qualified providers that render direct services. It also includes unlicensed staff rendering care under the supervision of a qualified provider.

LEA providers must be currently enrolled with DMAS in order to submit claims for services provided to Medicaid or FAMIS-enrolled members. Provider-related enrollment forms, including the Participation Agreement, can be found on the Virginia Medicaid Web Portal www.virginiamedicaid.dmas.virginia.gov.

LEA providers may submit claims to DMAS for medically necessary health care services approved for Medicaid and FAMIS members receiving special education and related services pursuant to an Individualized Education Program (IEP) through the LEA. (See Chapter IV of this manual for more information on covered services.)

LEA providers may also submit claims associated with providing the federally-required screening services that are part of the early and periodic screening, diagnostic and treatment services (EPSDT) benefit for Medicaid-enrolled students. See the EPSDT Supplemental Provider Manual available online at the Virginia Medicaid Web Portal for guidance on DMAS-covered well child visits and EPSDT screenings.

NATIONAL PROVIDER IDENTIFIER (NPI) AND LEA/ORP PROVIDER

ENROLLMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated that the Secretary of Health and Human Services adopt a standard unique identifier for health care providers. LEA providers, and qualified providers that order, refer or prescribe (ORP) DMAS-covered services for Medicaid and FAMIS members must obtain a National Provider Identifier (NPI) and submit the NPI to DMAS at the time of enrollment.

NPIs may be disclosed to other entities that need the health care providers' NPIs in order to carry out HIPAA standard transactions, as defined in 45 CFR Part 16, HIPAA Administrative Simplification: Standard Unique Health Identifier for Health Care Providers; Final Rule (NPI Final Rule).

This manual contains information about provider qualifications and specific details concerning the DMAS reimbursable services for LEAs. LEA providers, and their associated ORP and service rendering providers must comply with all sections of this manual and must practice in accordance with the requirements of the appropriate licensing board within the Department of Health Professions (as applicable) to maintain continuous participation in the DMAS Program.

PROVIDER REQUESTS FOR ENROLLMENT

DMAS strongly encourages LEA and ORP providers to register with the Virginia Medicaid Web Portal located at www.virginiamedicaid.dmas.virginia.gov. Registration with the portal is required in order to access and use the online enrollment and revalidation system. If a provider is unable to enroll electronically through the web portal, they can download a paper enrollment form from the Virginia Medicaid web-based portal and follow the instructions on the form for submission. It must be emphasized, however, that the provider must register with the Virginia Medicaid Web Portal in order to complete the provider revalidation process. (See Revalidation Requirements below.)

If you have any questions regarding the Virginia Medicaid Web Portal, please contact the Conduent Government Healthcare Solutions Support Help desk toll free, at 1-866-352-0496 from 8:00 a.m. to 5:00 p.m. Monday through Friday, except holidays. The MediCall audio response system provides similar information and can be accessed 24 hours per day, seven days per week by calling 1-800-884-9730 or 1-800-772-9996.

For questions regarding the online or paper enrollment process, please contact Provider Enrollment Services toll free at: 1-888-829-5373 or local 1-804-270-5105.

PROVIDER SCREENING REQUIREMENTS (LEA)

LEA billing and ORP providers must undergo a federally mandated comprehensive screening as part of the DMAS enrollment process. (See Limited Risk Screening Requirements below.). This comprehensive screening is repeated every five years as a part of the DMAS provider revalidation process. (See section below on Revalidation Requirements.) A partial screening process is also performed on a monthly basis for all currently enrolled providers.

Limited-Risk Screening Requirements

The following screening requirements will apply to limited-risk provider class types: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs. LEA providers and their associated ORP providers fall into this category.

Moderate-Risk Screening Requirements

The following screening requirements will apply to moderate-risk provider class types: Unannounced pre- and/or post-enrollment site visits in addition to those screening requirements applicable to the limited-risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every 5 years.

High-Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate-risk provider class types categories listed above, providers in the high-risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening.

Application Fees

If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and incorporated into the revalidation process.

The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

LEA providers, and ORP providers enrolling for purposes of LEA-based services, are not charged an enrollment fee.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If the application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected. (This does not apply to LEA providers or their employees or contractors.)

REVALIDATION REQUIREMENTS (LEA)

Qualified providers licensed through the Virginia Department of Health Professions (DHP) must follow DHP policies and procedures and maintain a valid, up-to-date license. DMAS system information is linked to the DHP system, so that no additional action on the part of the provider is required. Exception: Providers holding licenses that are administered by an entity other than DHP must update their licenses directly with DMAS.

All enrolled qualified providers in the Virginia Medicaid program will be notified in writing of a revalidation due date, and informed of new or revised provider screening requirements in the revalidation notice. Providers must complete the revalidation process using the DMAS web portal. If a provider is currently enrolled as a Medicare provider, DMAS may rely on the enrollment and screening facilitated by CMS to satisfy our provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS (LEA)

The Code of Federal Regulations 455:410(b) requires ORP providers to enroll to meet ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid enrollees originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid.

LEA AND ORP PROVIDER PARTICIPATION REQUIREMENTS

Providers enrolled with DMAS must perform the following activities as well as any other

specified by DMAS:

- Immediately notify the Provider Enrollment Unit, in writing, of any change in the information which the provider previously submitted to the Provider Enrollment Unit.
- Avoid actions that would restrict a member from seeking covered services from any institution, pharmacy, or practitioner that is enrolled with DMAS and qualified to perform necessary covered services.
- Ensure the recipient's freedom to reject medical care and treatment.
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the ground of race, color, or national origin.
- Provide services, goods, and supplies to recipients in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities.
- Provide recipients the same quality of service and in the same mode of delivery as provided to the general public.
- Accept DMAS payment from the first day of eligibility if the provider was aware that application for Medicaid or FAMIS eligibility was pending at the time that services began.
- Accept as payment in full the amount established by DMAS to be reasonable cost or maximum allowable charge. 42 CFR §447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by the agency." A provider may not bill a recipient for a covered service regardless of whether the provider received payment from the state. The provider may not seek to collect from a Medicaid/FAMIS recipient, or any financially responsible relative or representative of that recipient, any amount that exceeds the established DMAS allowance for the service rendered. The provider may not charge DMAS or the recipient for broken or missed appointments.
- Accept assignment of Medicare benefits for eligible Medicaid recipients.
- Use Program-designated billing forms for submission of charges.
- Maintain and retain business and professional records sufficient to document fully and accurately the nature, scope, and details of the health care provided. Refer to Chapter VI of this manual for specific record retention policy.
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities.
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or

other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to recipients of medical assistance.
- Hold confidential, and use for authorized DMAS purposes only, all medical assistance information regarding recipients. A provider shall disclose information in his or her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of DMAS. DMAS shall not disclose medical information to the public.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES (LEA)

DMAS payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the individual or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the DMAS payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated with an excluded provider. A provider who employs or contracts with an excluded individual or entity for the provision of items or services reimbursable by DMAS may be subject to overpayment liability as well as civil monetary penalties. All LEA providers are required to immediately report to DMAS any exclusion information discovered. Such information should be sent in writing and should include the individual or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Suite 1300

Richmond, VA 23219

-or-

E-mailed to: providerexclusions@dmas.virginia.gov

SPECIAL PARTICIPATION REQUIREMENTS

The following paragraphs outline the special participation conditions for LEA billing providers and their associated qualified providers performing covered services. Qualified providers must meet all qualifications and requirements for their specialty as defined in State law, and they must be employed by or contracted by the billing LEA.

DMAS covers the following school-based services: (Service conditions are covered in Chapter IV of this manual.)

- Well child visits and EPSDT screenings (see the EPSDT Supplemental Provider Manual),
- Physical therapy,
- Occupational therapy,
- Speech-language therapy,
- Audiology,
- Nursing,
- Psychiatry, psychology and mental health,
- Personal care,
- Medical evaluations,
- Specialized Transportation, and
- Evaluations for DMAS billable special education and related services.

LEAs must:

- Utilize DMAS-qualified providers to provide DMAS-billable services as required by state law and regulations;
- Include an NPI of a DMAS-enrolled ORP provider on school-based service claims, with the exception of personal care and specialized transportation services, and medical evaluation services performed by a physician, nurse practitioner or physician's assistant.

The following DMAS-qualified providers of LEA school-based services must enroll with DMAS as ORP providers in order to refer for billed services within the program:

Audiologists	Physicians including Psychiatrists
Clinical Psychologists	Professional Counselors
Clinical Social Workers	Psychiatric Clinical Nurse Specialists
Marriage and Family Therapists	School Psychologists
Nurse Practitioners	School Psychologists (Limited)
Occupational Therapists	School Social Workers
Physical Therapists	Speech-Language Pathologists (master's level only)

The following providers may not act as ORP providers of LEA school-based services, and are not required to obtain an NPI number or enroll with DMAS:

- Registered nurses, licensed practical nurses
- Personal care assistants
- School specialized transportation providers
- Occupational therapy assistants
- Physical therapy assistants
- Bachelors level speech-language pathologists
- Psychological testing technicians

DMAS does not reimburse services provided by a parent, stepparent or legal guardian of the student. Payment may be made for services rendered by other family members. In those circumstances, the family member providing therapy or other service to the student must be employed by or under contract with the LEA and must meet all DMAS-required provider qualifications.

PROVIDER QUALIFICATIONS FOR SPECIFIC SERVICES

Requirements for Providing Clinical Supervision According to Board Licensing Requirements

In addition to the requirements listed in the LEA Provider Manual, DMAS-qualified providers providing clinical supervision to professionals according to Virginia licensing board requirements must follow their individual licensing-related laws and regulations regarding supervision requirements as detailed in the Code of Virginia and Virginia Administrative Code, as applicable. This includes requirements for direct (face-to-face) supervision versus indirect (telephonic or off-site) supervision, and the frequency of supervisory visits.

If the individual licensing or special education requirements do not include specific time periods regarding supervisory visits (e.g., every 30 days) or type of supervisory visits (e.g., in-person), then the qualified supervising provider shall complete supervisory visits with the supervisee at least every 90 days, to ensure both the quality and appropriateness of the services provided, and to make any needed adjustments to the treatment plan. Supervision may be provided indirectly (e.g., telephonically), if allowed under the individual licensing requirements. The supervisor must document supervisory activities as described in Chapter VI of this manual.

Supervision of Personal Care Assistants

Any licensed practitioner who meets DMAS qualified provider requirements stated in this chapter may supervise the personal care assistant (PCA) providing services within the scope of the licensed practitioner's individual discipline. In cases where a single PCA is providing personal care services to a student based on multiple service-specific plans of care, the PCA's work must be supervised by a qualified providers from each of the services involved.

Examples of PCA services and suggestions for the appropriate supervising licensed practitioner of the healing arts include:

- Assistance to increase adaptive behavioral functioning supervised by the licensed provider of psychiatry, psychological or mental health services;
- Assistance with activities of daily living supervised by the physical therapist (PT), occupational therapist (OT), speech and language pathologist (SLP) or RN;
- Assistance with hearing aids and assistive listening devices supervised by the audiologist or SLP;
- Assistance with adaptive equipment supervised by OT, PT, or SLP;
- Assistance with ambulation and exercise supervised by the PT or OT;
- Assistance with remedial services to reduce the impact of the disability, supervised by a DMAS approved provider as documented in this chapter; and
- Monitoring a health related service supervised by a RN.

Physical Therapy Services

Physical therapy services must be performed by the following:

- A physical therapist (PT) licensed by the Virginia Board of Physical Therapy; or
- A physical therapy assistant (PTA) licensed by the Virginia Board of Physical Therapy under the supervision of a PT.

Occupational Therapy Services

Occupational therapy services must be performed by the following:

- An occupational therapist (OT) licensed by the Virginia Board of Medicine; or
- An occupational therapy assistant (OTA) licensed by the Virginia Board of Medicine under the supervision of a licensed occupational therapist.

Speech-Language Therapy Services

Speech-language therapy services must be performed by:

- A speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology with a Master's Degree*; or
- A SLP licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology with licensure as school speech-language pathologist without a Master's degree, under the supervision of a licensed SLP with a Master's Degree.

*A master's level SLP with a Virginia Board of Audiology and Speech Language Pathology provisional license is considered a qualified provider of LEA services and does not require supervision.

Audiology Services

Audiology services must be provided by an audiologist licensed by the Virginia Board of Audiology and Speech-Language Pathology.

Nursing Services

Nursing services must be provided by a:

- Licensed Registered Nurse (RN); or
- Licensed Practical Nurse (LPN) under the supervision of a RN as required by the Virginia Board of Nursing.

Psychiatry, Psychology, and Mental Health Services

Psychiatry, psychology and mental health services may be provided by:

- A psychiatrist licensed by the Board of Medicine;
- A licensed clinical psychologist, licensed school psychologist, or licensed school psychologist-limited licensed by the Board of Psychology;
- A licensed clinical social worker (LCSW) licensed by the Board of Social Work;
- A licensed professional counselor (LPC) licensed by the Board of Counseling;

- A psychiatric clinical nurse specialist (CNS) licensed by the Board of Nursing and certified by the American Nurses Credentialing Center;
- A licensed marriage and family therapist (LMFP) licensed by the Board of Counseling; or
- A school social worker endorsed by Department of Education.

Psychological Testing Technicians

A DMAS qualified provider acting within the scope of his or her licensure may utilize a psychological testing technician* to administer psychological tests as a component of the psychological testing evaluation service. The qualified provider must provide general supervision which, in this context, means under the qualified provider's overall direction and control, but his or her presence is not required during the performance of the procedure.

*It is acceptable for a psychology intern to perform the role of psychological testing technician. These services may be billed as long as the testing technician/psychology intern is a LEA-paid position.

Personal Care Assistant Services

Basic qualifications for PCAs include:

- Physical ability to do the work;
- Ability to be trained by appropriate licensed professional to perform tasks;
- Perform services consistent with the training received by the appropriate DMAS qualified provider.

Training and supervision of PCAs must be provided by the appropriate, discipline-specific DMAS qualified provider of the services as listed in the plan of care.

Medical Evaluation Services

Qualified providers of medical evaluation services include:

- A physician licensed by the Board of Medicine;

- A physician assistant licensed by the Board of Medicine; or
- A nurse practitioner licensed by the Board of Nursing.

Well Child Visits and EPSDT Screening Services

Well child visits and EPSDT screening services must be conducted by:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine; or
- A nurse practitioner licensed by the Board of.

See the EPSDT Supplemental Provider Manual available online at the Virginia Medicaid Web Portal for guidance on DMAS-covered well child visits and EPSDT screenings.

Specialized Transportation

Providers of specialized transportation services must be employed through the LEA or have a contract with the LEA, and must meet applicable federal and state statutes and regulations for transporting students. The specialized transportation vehicle must be a specially adapted school vehicle utilized to transport a Medicaid or FAMIS-enrolled student from (to) their home or other "originating site" to (from) the site where they are receiving a DMAS billable and paid service that is documented in the student's IEP.

Note: Specialized transportation service is not covered by the VA Medicaid Non-Emergency Transportation (NET) Brokerage program. Specialized transportation arrangements and services are provided only by the LEA.

REQUIREMENTS OF SECTION 504 OF THE REHABILITATION ACT

Section 504 of the Rehabilitation Act of 1973, as amended, (29 U.S.C. § 794) provides that no individual with a disability shall, solely by reason of the disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal assistance. Each Medicaid participating provider is responsible for making provisions for such disabled individuals in the provider's programs and activities.

As an agent of the federal government in the distribution of funds, DMAS is responsible for monitoring the compliance of individual providers. The provider's signature on the claim indicates their attestation of compliance with the Rehabilitation Act.

In the event a discrimination complaint is lodged, DMAS is required to provide to the Office of Civil Rights (OCR) any evidence regarding non-compliance with these requirements.

TERMINATION OF PROVIDER PARTICIPATION (LEA)

The participation agreement will be time-limited with periodic renewals required. DMAS will request a renewal of the Participation Agreement prior to its expiration.

A participating provider may terminate participation with DMAS at any time; however, written notification of voluntary termination must be made to the Provider Enrollment Unit thirty (30) calendar days prior to the effective date.

DMAS may terminate a provider from participation upon thirty (30) calendar days written notification prior to the effective date. Such action precludes further payment by DMAS for services provided to recipients subsequent to the date specified in the termination notice.

Subsection 32.1-325 D.2 of the *Code of Virginia* mandates that "Any such Medicaid agreement or contract shall terminate upon conviction of the provider of a felony." A provider convicted of a felony in Virginia or in any other of the 50 states must, within 30 calendar days, notify the Department of this conviction and relinquish the agreement. Reinstatement will be contingent upon the provisions of State law.

Appeals of Provider Termination or Enrollment Denial: A Provider has the right to appeal in any case in which a Medicaid agreement or contract is terminated or denied to a provider pursuant to Virginia Code §32.1-325D and E. The provider may appeal the decision in accordance with the Administrative Process Act (Virginia Code §2.2-4000 et seq.). Such a request must be in writing and must be filed with the DMAS Appeals Division **within 15 calendar days** of the receipt of the notice of termination or denial.

Appeals of Adverse Actions

Definitions:

Administrative Dismissal – means:

1) A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or

2) The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action – means the termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination – Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) The reduction, suspension, or termination of a previously authorized service; (iii) The denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) The failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) For a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities. The denial, in whole or in part, of payment for a service solely because the claim does not meet the definition of a "clean claim" at § 447.45(b) is not an adverse benefit determination.

Appeal – means:

1) A member appeal is:

   a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

   b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2) For services that have already been rendered, a provider appeal is:

   a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

   b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Internal Appeal – means a request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Reconsideration – means a provider's request for review of an adverse action. The MCO's or DMAS Contractor's reconsideration decision is a pre-requisite to a provider filing an appeal to the DMAS Appeals Division.

State Fair Hearing – means the Department's *de novo* evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts *de novo* evidentiary hearings in accordance with regulations at 42 C.F.R. § 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

Transmit – means to send by means of the United States mail, courier or other hand delivery, facsimile, electronic mail, or electronic submission.

MEMBER APPEALS

Information for providers seeking to represent a member in the member's appeal of an adverse benefit determination is located in Chapter III.

PROVIDER APPEALS

Non-State Operated Provider

The following procedures will be available to all non-state operated providers when an adverse action is taken that affords appeal rights to providers.

If the provider chooses to exercise available appeal rights, a request for reconsideration must be submitted if the action involves a DMAS claim under the EAPG payment methodology or involves a ClaimCheck denial. The request for reconsideration and all supporting documentation must be submitted within 30 days of the receipt of written notification of the underpayment, overpayment, and/or denial to the attention of the Program Operations Division at the following address:

Program Operations Division

Department of Medical Assistance Services

600 East Broad Street,

Richmond, Virginia 23219

DMAS will review the documentation submitted and issue a written response to the provider's request for reconsideration. If the adverse decision is upheld, in whole or part, as a result of the reconsideration process, the provider may then appeal that decision to the DMAS Appeals Division, as set forth below.

Internal appeal rights with a managed care organization ("MCO") must also be exhausted prior to appealing to DMAS if the individual is enrolled with DMAS through a Virginia Medicaid MCO.

For services that have been rendered and applicable reconsideration or MCO internal appeal rights have been exhausted, providers have the right to appeal adverse actions to DMAS.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in the Code of Virginia § 2.2-4000 *et. seq.* and the Virginia Administrative Code 12 VAC 30-20-500 *et. seq.*

Provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or final reconsideration/MCO internal appeal decision. However, provider appeals of a termination of the DMAS provider agreement that was based on the provider's conviction of a felony must be appealed **within 15 calendar days** of the provider's receipt of the DMAS adverse action. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues from the action being appealed. Failure to file a written notice of informal appeal within the prescribed timeframe will result in an administrative dismissal of the appeal.

The appeal must be filed with the DMAS Appeals Division through one of the following methods:

- Through the Appeals Information Management System ("AIMS") at

https://www.dmas.virginia.gov/appeals/. From there you can fill out an informal appeal request, submit documentation, and follow the process of your appeal.

- Through mail, email, or fax. You can download a Medicaid Provider Appeal Request form at https://www.dmas.virginia.gov/appeals/. You can use that form or a letter to file the informal appeal. The appeal request must identify the issues being appealed. The request can be submitted by:
    - Mail or delivery to: Appeals Division, Department of Medical Assistance Services, 600 E. Broad Street, Richmond, VA 23219;
    - Email to appeals@dmas.virginia.gov; or
    - Fax to (804) 452-5454.

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. will be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date will be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision will result in dismissal of the appeal. The notice of appeal must be transmitted through the same methods listed above for informal appeals.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the APA at the Code of Virginia § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

Repayment of Identified Overpayments

Pursuant to § 32.1-325.1 of the *Code of Virginia*, DMAS is required to collect identified overpayments. Repayment must be made upon demand unless a repayment schedule is agreed to by DMAS. When lump sum cash payment is not made, interest shall be added on the declining balance at the statutory rate, pursuant to the *Code of Virginia*, § 32.1-313.1. Repayment and interest will not apply pending the administrative appeal. Repayment schedules must ensure full repayment within 12 months unless the provider demonstrates, to the satisfaction of DMAS, a financial hardship warranting extended repayment terms.

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for

services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director's decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

DMAS PROGRAM INFORMATION

Federal regulations governing program operations require Virginia DMAS to supply program information to all providers. The current system for distributing this information is keyed to the provider number on the enrollment file, which means that each assigned provider receives program information.

A provider may not wish to receive a provider manual and DMAS memoranda because he or she has access to the publications as part of a group practice. To suppress the receipt of this information, the Provider Enrollment Unit requires the provider to complete the Mail Suppression Form and return it to:

Virginia Medicaid Provider Enrollment Services

P.O. Box 26803

Richmond, VA 23261-6803

Phone (804) 270-5105 or 1-888-829-5373 (In-state Toll Free)

Fax (804) 270-7027 or 1-888-335-8476

Upon receipt of the completed form, PEU will process it and the provider named on the form will no longer receive publications from DMAS. To resume the mailings, a written request sent to the same address is required.

Member Eligibility

Determining Eligibility

The Department of Medical Assistance Services (DMAS) administers Virginia's medical assistance programs: Medicaid (called FAMIS Plus for children), FAMIS for children under age 19 years, and FAMIS MOMS for pregnant women. FAMIS and FAMIS MOMS offer coverage similar to Medicaid but have higher income thresholds. Per state regulations, eligibility determinations for the medical assistance programs are made by the local departments of social services (LDSS) and by the Cover Virginia Central Processing Unit (CPU).

Inquiries from persons who wish to apply for medical assistance should be referred to the LDSS in the locality in which the applicant resides, to the Cover Virginia Call Center at 1-855-242-8282, or the Cover Virginia website at www.CoverVA.org. DMAS will not pay providers for services, supplies, or equipment until the applicant's eligibility has been determined. (See "Assistance to Patients Possibly Eligible for Benefits.") Once an applicant has been found eligible, coverage for Medicaid can be retroactive for up to three months before the month in which the application was filed. A member's eligibility must be reviewed when a change in the member's circumstances occurs, and all members are subject to an annual renewal (redetermination) of eligibility.

Groups Covered by Medical Assistance

Individuals who apply for Medicaid are evaluated under the covered group or groups they meet. Each covered group has a prescribed income limit, and some covered groups also have an asset or resource limit. . Individuals may be eligible for full medical assistance coverage, including the payment of Medicare premiums for Medicaid members with Medicare, if they fall into one of the following covered groups and meet the nonfinancial and financial requirements for the group:

- Auxiliary Grants (AG) recipients
- Aged, blind or disabled (ABD) recipients of Supplemental Security Income (SSI) and certain former SSI recipients with "protected" status

- ABD individuals with income less than or equal to 80% of the Federal Poverty Level (FPL) who are age 65 or older and/or who are eligible for or enrolled in Medicare.
- Low-Income Families with Children (parents with a dependent child under age 18 years in the home)
- Pregnant women, and postpartum women through the end of the 60-day postpartum period (Medicaid, FAMIS MOMS)
- Newborns up to age one year born to mothers who were eligible for Medicaid or covered by FAMIS or FAMIS MOMS at the time of the birth
- Children in foster care or subsidized adoptions, and individuals under age 26 who were formerly in foster care until their discharge from foster care at age 18 or older.
- Children under age 19 years (FAMIS Plus, FAMIS)
- Adults between the ages of 19 and 64 who are not eligible for or enrolled in Medicare. These individuals are referred to as Modified Adjusted Gross Income (MAGI) Adults.
- Individuals under age 21 in institutional care
- Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)—women and men who were certified through the Breast and Cervical Cancer Early Detection Program.
- Individuals who are in long-term care institutions or receiving services under a home and community-based care waiver, or who have elected hospice care

The following individuals may be eligible for limited Medicaid coverage if they meet the nonfinancial and financial requirements for their covered group:

- Qualified Medicare Beneficiaries (QMBs) with income over 80% of the FPL but within 100% of the FPL. This group is eligible for **Medicaid coverage of Medicare premiums, deductibles, and coinsurance only**.
- Special Low-Income Medicare Beneficiaries (SLMB) with income less than 120% of the FPL. This group is eligible for Medicaid coverage of **Medicare Part B premiums only**.
- Qualified Individuals (QI) with income equal to or greater than 120% but less than 135% of the FPL. This group is eligible for Medicaid coverage of the **Medicare Part B premiums only**.
- Qualified Disabled and Working Individuals (QDWI) with income up to 200% of the FPL. This group is eligible for Medicaid payment of **Medicare Part A premiums only**.
- Plan First – any individual with income equal to or less than 200% of FPL. This group is eligible for limited Medicaid coverage of family planning services only and not covered for full Medicaid benefits. If a member does not wish to be enrolled in Plan First, he or she should contact the local DSS to be disenrolled.

Medically Needy Covered Groups and Spenddown

Through a process known as “spenddown,” Medicaid provides a limited period of full coverage for certain groups of “Medically Needy” individuals who meet all of the Medicaid eligibility requirements but have excess income for full benefit Medicaid. Individuals to which spenddown may apply include:

- ABD individuals
- Pregnant women and their newborn children
- Children under age 18
- Individuals under Age 21 in institutional care, under supervision of the Department of Juvenile

Justice, foster care, or subsidized adoptions
- Individuals in long-term care institutions and those receiving services under a home and community-based care waiver or who have elected hospice care.

To be eligible for Medicaid, the individual must have incurred medical expenses that at least equal the spenddown liability. If the individual's allowable medical expenses equal the spenddown liability amount before the end of a budget period (six-month period for noninstitutionalized individuals or a one month period for institutionalized individuals), the applicant may receive a limited period of Medicaid coverage which will stop at the end of the budget period. The spenddown liability is the difference between the individual's income and the Medically Needy income limit for the individual's locality, multiplied by the number of months in the individual's spenddown period. Eligibility must be re-determined in order to establish eligibility in subsequent budget periods.

An individual placed on a spenddown does **not** have full Medicaid coverage until the spenddown is met, however they may be eligible for limited Medicaid coverage, Plan First, during the spenddown period. Medicaid cannot pay medical expenses incurred prior to the date the spenddown is met.

Emergency Medicaid Services for Aliens

To be eligible for full Medicaid benefits, FAMIS or FAMIS MOMS, an individual must be a resident of Virginia and a U.S. citizen or an alien qualified for full benefits. Individuals who do not qualify for full Medicaid benefits due to their alien status may be eligible for Medicaid coverage of emergency services if they meet all other nonfinancial and financial eligibility requirements for full Medicaid coverage.. The FAMIS and FAMIS MOMS programs do not cover emergency services for undocumented immigrants.

LDSS staff determine eligibility for receipt of emergency Medicaid coverage based on regular eligibility criteria and documentation from the provider of services that emergency services were provided. The provider may refer the individual to the LDSS or Cover Virginia (see Chapter I for information on the covered services and the coverage criteria.) For the purposes of this section, labor and delivery are considered emergency services.

Receipt of the emergency treatment will be verified by the LDSS through the member's medical record obtained from the provider. The LDSS will send a written request to the provider for the necessary documentation of the emergency service. This documentation must include all required Medicaid forms and a copy of the member's complete medical record. For inpatient hospital stays, this documentation will be the medical record for the entire hospitalization up to the 21-day limit for those over age 20.

The LDSS is authorized to approve labor and delivery services of up to three days for a vaginal delivery and five days for a cesarean section. All other services will be referred to DMAS for approval of the coverage of treatment and for establishment of the time for which this coverage will be valid.

If the member is found eligible and the emergency coverage is approved by DMAS, each provider rendering emergency care will be notified via the Emergency Medical Certification Form (#032-03-628) of the member's temporary eligibility number for coverage of the treatment of the

conditions during the time stated on this form. This form will also be used to notify providers if an alien is not eligible for emergency care (See “Exhibits” at the end of this chapter for a sample of this form.).

Medicaid Eligibility for Institutionalized Individuals

An institutionalized individual is defined as one who is receiving long-term services and supports (LTSS) as an inpatient in a medical institution or nursing facility or in the home or community setting. Home and community based services (HCBS) include waiver services such as personal care, adult day health care, respite care, and the Program for All Inclusive Care for the Elderly (PACE).

To be approved for Medicaid-covered LTSS, the individual must be institutionalized in a nursing or other medical facility or have been screened and approved for HCBS. and be eligible for Medicaid in a full-benefit covered group.

If an individual is not eligible for Medicaid in any other full-benefit covered group, the individual’s eligibility in the one of the special income covered groups is determined. The policy for these groups allows a different method of determining income and resource eligibility, a higher income limit of 300% of the SSI payment for one person., An married institutionalized individual's spouse at home is referred to as the community spouse. The community spouse is able to retain a specified amount of resources in order to continue to meet maintenance needs in the community. Some of the institutionalized spouse’s monthly income may also be allocated to the community spouse if certain criteria are met. Atthe time of application for Medicaid, the LDSS completes the resource assessment document, which produces a compilation of a couple's combined countable resources at the time one spouse became institutionalized and a calculation of a spousal share (the amount of shared resources that can be allocated to the community spouse). An institutionalized spouse with a community spouse may also request a resource assessment without submitting a Medicaid application to assist with financial planning.

Most individuals receiving LTSS have an obligation toward the cost of their care, known as the patient pay. MAGI adults do not have a patent pay responsibility.

Family Access to Medical Insurance Security (FAMIS) Plan

Section 4901 of the Balanced Budget Act of 1997 (BBA) amended the Social Security Act (the Act) by adding a new title XXI, the State Children’s Health Insurance Program (SCHIP). Title XXI provides funds to states to enable them to initiate and expand the provision of child health assistance to uninsured, low-income children in an effective and efficient manner.

Virginia’s Title XXI program is known as FAMIS and is a comprehensive health insurance program for Virginia’s children from birth through age 18 who are not covered under other health insurance and whose income is over the Medicaid income limit and under 200 percent of the Federal Poverty Level. FAMIS is administered by DMAS and is funded by the

state and federal government.

FAMIS Covered Services

FAMIS covered services are somewhat different from Medicaid covered services. One of the key differences is that most children enrolled in the FAMIS Program are not eligible for EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO). Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The following services are covered for FAMIS enrollees:

- Abortion only if necessary to save the life of the mother
- Behavioral therapies including, but not limited to, applied behavior analysis;
  - Assistive technology
  - Blood lead testing
- Chiropractic with benefit limitations
- Clinic services (including health center services) and other ambulatory health care services
- Community Mental Health Rehabilitation Services (CMHRS) including:
  - Intensive in-home services
  - Therapeutic day treatment
- Mental health crisis intervention
- Case management for children at risk of (or with) serious emotional disturbance
- Dental services (includes diagnostic, preventive, primary, orthodontic, prosthetic and complex restorative services)
- Durable medical equipment, prosthetic devices, hearing aids, and eyeglasses with certain limitations
- Disposable medical supplies
- Early Intervention services including targeted case management
- Emergency hospital services
- Family planning services, including coverage for prescription drugs and devices approved by the U.S. Food and Drug Administration for use as contraceptives
- Gender dysphoria treatment services
- Home and community-based health care services (includes nursing and personal care services, home health aides, physical therapy, occupational therapy, and speech, hearing, and inhalation therapy)

- Hospice care including care related to the treatment of the child's condition with respect to which a diagnosis of terminal illness has been made
- Inpatient substance abuse treatment services, with the following exceptions: services furnished in a state-operated mental hospital, services furnished in IMDs, or residential services or other 24-hour therapeutically planned structural services
- Inpatient services (365 days per confinement; includes ancillary services)
- Inpatient acute mental health services in general acute care hospital only. Does not include those (a) services furnished in a state-operated mental hospital, (b) services furnished by IMDs, or (c) residential services or other 24-hour therapeutically planned structural services
- Maternity services including routine prenatal care
- Medical formula, enteral/medical foods (sole source, specialized formula – not routine infant formula)
- Nurse practitioner services, nurse midwife services, and private duty nursing services are covered. Skilled nursing services provided for special education students are covered with limitations
- Organ transplantation
- Outpatient mental health services, other than services furnished in a state-operated mental hospital
- Outpatient substance abuse treatment services, other than services furnished in a state-operated mental hospital. These include intensive outpatient, partial hospitalization, medication assisted treatment, case management, and peer support services
- Outpatient services, including emergency services, surgical services, clinical services, and professional provider services in a physician's office or outpatient hospital department
- Outpatient diagnostic tests, X-rays, and laboratory services covered in a physician's office, hospital, independent and clinical reference lab (including mammograms);
- Prescription drugs (mandatory generic program) and over-the-counter (optional for managed care)
- Peer support services
- Physician services, including services while admitted in the hospital, or in a physician's office, or outpatient hospital department
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders
- School based health services
- Skilled nursing facility
- Surgical services
- Transportation - professional ambulance services only to medically necessary covered services (fee-for-service members have routine access to and from providers of covered medical services)

- Vision services
- Well-child care, including visits, laboratory services as recommended by the American Academy of Pediatrics Advisory Committee, and any immunizations as recommended by the Advisory Committee on Immunization Practice (ACIP)

Member Copays

FAMIS does not have yearly or monthly premiums. However, children who are enrolled in a MCO must pay co-payments for some covered services. There are no co-payments required for preventative services such as well-child care, immunizations, or dental care. The chart below shows the co-payment amounts for some basic FAMIS services for children who are enrolled in a MCO, based on co-pay status.

NOTE: Native Americans and Alaskan Natives do NOT have any co-payments.

SERVICE*	**Co-pay Status 1**	**Co-pay Status 2**
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Member Eligibility Card

A blue and white plastic eligibility card is issued to members to present to participating providers. Plan First members receive a green and white identification card. **The provider is obligated to determine that the person to whom care or service is being rendered is the same individual listed on the eligibility card.** The provider has the responsibility to request such identification as he or she deems necessary. Presentation of a plastic ID card is not proof of coverage nor guarantee of payment. A sample of an eligibility card is included under "Exhibits" at the end of this chapter.

Eligibility must be confirmed each time service is rendered. Verification can occur through a verification vendor, the voice response system or the web-based verification system. LDSS do not provide verification of eligibility to providers.

Some individuals have coverage under a Virginia Medicaid/FAMIS contracted managed care organization (MCO) and should not receive services outside their network without a referral and

authorization from the MCO. These members will have an MCO card in addition to the Medicaid/FAMIS card. The verification response will advise if the member has restrictions such as a contracted MCO enrollment, or a primary payer.

The provider must determine if the service is within the dates of eligibility. These dates must be checked prior to rendering any service. Benefits are available only for services performed during the indicated period of eligibility; Medicaid/FAMIS will not pay for care or services rendered before the beginning date or after the end date of eligibility.

Bank Identifier
The top six numbers on the plastic card represent the Bank Identifier Number (BIN), which is required for pharmacy benefit cards under the National Council of Prescription Drug Programs (NCPDP).

Name of Eligible Person
An eligibility card is issued to each person eligible for full Medicaid/FAMIS benefits and QMBs. Members enrolled in Plan First receive a green and white identification card. Check the name against another proof of identification if there is any question that the card does not belong to the member.

Member's Eligibility Number
The member's complete eligibility number is embossed on the front of the eligibility card. Eligibility numbers are distinct and permanent. When a member relocates or moves into another case, or has a break in eligibility, he keeps the same number and the same card. When members are enrolled in Plan First, they will receive a green and white identification card. This number serves as a "key" in verifying current eligibility status.

All 12 digits must be entered on Medicaid forms for billing purposes.

Date of Birth
The date of birth indicates the member's age and identifies eligibility for those services with age restrictions, such as dental care for members under age 21 and pregnant women. The date of birth should be checked prior to rendering any services. The provider should verify the age of the member. If the provider has a question as to the age of the member, means of identification other than the Medicaid/FAMIS card should be examined.

Sex
The member's gender is indicated on the card.

Card #
The sequential number of the member's card is given. If a card is lost or stolen and another Manual Title All Manuals Chapter III Page 7 Chapter Subject Member Eligibility Page Revision Date 02/22/2019 is issued, the prior card will be de-activated and will not confirm eligibility using the magnetic "swipe" mechanism.

Cardholder's Signature (signature line on back)
The signature line provides another element of verification to confirm identity

Verification of Member Eligibility

It is the obligation of the provider of care to determine the identity of the person named on the eligibility card and the current eligibility status, to include program type or MCO enrollment. It is in the best interest of the provider to review the card each time services are rendered. Possession of a card does not mean the holder is currently eligible for benefits. The member does not relinquish the card when coverage is cancelled. Replacement cards must be requested.

Program/Benefit Package Information

Members' benefits vary depending upon the program in which they are enrolled. The eligibility verification will provide information on which program the member is participating in. Examples of these programs include Medallion 3.0, Medicaid fee-forservices, FAMIS MCO, CCC Plus, FAMIS fee-for-service and Medicare premium payment.

Limited Benefit Programs for Which Members Receive Eligibility Cards

The Medicare Catastrophic Coverage Act of 1988 and other legislation require State Medicaid Programs to expand the coverage of services to QMBs. There are two levels of coverage for QMBs, based on financial eligibility.

QMB Coverage Only—Members in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the member's copayment on allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage—Members in this group are dually-eligible for full Medicaid coverage and Medicare. They are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for all Medicare-covered services plus coverage of all other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These members are responsible for copays for pharmacy services, health department clinic visits, and vision services.

SLMBs and QIs do not receive member eligibility cards because they are not eligible for the payment of medical services rendered.

Plan First—Men and women enrolled in Plan First can receive limited Medicaid covered family planning services only, and they receive a green and white plastic Plan First identification card. This group's Medicaid verification provides the message, "PLAN FIRST - FAMILY PLANNING SERVICES ONLY." See the Plan First Manual for more information.

All Others—Members without ANY of these messages at time of verification will be eligible for those covered services listed in Chapter I of this manual.

Special Indicator Code (Copayment Code)

The Special Indicator Code indicates the status of copayments or eligibility for certain additional services. These codes are:

Code	Message
A	Under 21 - No copay exists.
B	Individuals Receiving Long-Term Care Services, Home or Community-Based Waiver Services, or Hospice Care - No copay is required for any service.
C	All Other Members - Copays apply for inpatient hospital admissions, outpatient hospital clinic visits, clinic visits, physician office visits, other physician visits, eye examinations, prescriptions, home health visits, and rehabilitation service visits. (Some verification methods may return a yes/no response. Yes = copays apply. No = copays do not apply)

The following copay exemptions apply:

- Members in managed care organizations may not have to pay copays.
- Pregnancy-related services or family planning clinic visits, drugs, and supplies are exempt from copays for all members.
- No copayments apply for any emergency services for any member, with one exception for members in Client Medical Management with a pharmacy restriction. Please refer to the Client Medical Management exhibit in Chapter I for more information on this exception.

The Medicaid member co-pays are located in Chapter IV.

The FAMIS member co-pays are:

Service*	Co-pay Status 1	Co-pay Status 2
Outpatient Hospital or Doctor	$2 per visit	$5 per visit
Prescription Drugs	$2 per prescription	$5 per prescription
Inpatient Hospital	$15 per admission	$25 per admission
Non-emergency use of Emergency Room	$10 per visit	$25 per visit
Yearly Co-payment Limit per Family	$180	$350

*Other co-payments may apply to other services.

Insurance Information The “Insurance Information” in the verification response indicates any type of insurance coverage the member has in addition to Medicaid. This information includes specific insurance companies, dates of coverage, policy numbers, and a code that specifies the particular type of coverage of the policy. These items are:

Carrier Code	A three-digit code indicating the name of the insurance carrier, e.g. 001 for Medicare (See Insurance Company Code List for these code numbers in “EXHIBITS” at the end of this chapter.) If the carrier code is 003 (not listed), call the member’s local eligibility worker for assistance in obtaining the name of the insurance carrier.
Begin Date	The first date on which this insurance policy was effective
Type Code	An alpha character describing the type of coverage provided by the policy, such as a "D" for dental coverage. (See the Type of Coverage Code List under “EXHIBITS” at the end of this chapter for a list of these codes.)
Policy Number/ Medicare Code	The specific policy or Medicare number for the insurance identified by the Carrier Code

Only insurance information for active policies during the period for which eligibility is requested is provided at verification. If the member reports insurance information different from what is on the card, refer the member to his or her LDSS eligibility worker to correct the data so bills will be processed correctly.

Under the assignment of benefits regulations, DMAS can act on behalf of the member (subscriber) and recover third-party payment from the primary carrier. Workers' Compensation and other liability insurances (e.g., automobile liability insurance or home accident insurance) are always considered as primary carriers for cases where coverage is applicable to the injury being treated. Because the member's eligibility card cannot indicate this coverage, it is necessary that cause-of-injury information be obtained from the member.

Primary Care Providers (PCPs) for the Client Medical Management Program

A primary care designation or restriction is imposed by the Member Monitoring Unit of DMAS as a result of high utilization of services by the member causing unnecessary or duplicate services. Eligibility verification will list the names of designated primary care providers (physician and/or pharmacy). The designated providers must agree to the relationship prior to the designation appearing on the member's card. Unless it is an emergency, do not provide services without contacting the primary care provider first for authorization.

Managed Care Programs

Most Medicaid members are enrolled in one of the Department’s managed care programs (Medallion 3.0, Medallion 4.0, CCC Plus, PACE). Each program has specific eligibility requirements and health plan assignment criteria for its members. For more information, please contact the individual’s managed care plan/PACE provider directly.

Contact and/or eligibility and assignment information for managed care plans can be found on the DMAS website for each program as follows:

- Medallion 3.0: http://www.dmas.virginia.gov/#/med3
- Medallion 4.0:

http://www.dmas.virginia.gov/#/med4
- Commonwealth Coordinated Care Plus (CCC Plus): ttp://www.dmas.virginia.gov/#/cccplus
- Program of All-Inclusive Care for the Elderly (PACE): http://www.dmas.virginia.gov/#/longtermprograms

Member Without an Eligibility Card

A member who seeks services without a current eligibility card should be considered responsible for all charges incurred unless eligibility is verified. The provider can verify eligibility without the card using two other identification keys, including name, Social Security Number, and date of birth. These can be used to access the MediCall automated System, the verification vendors, and the web verification system (ARS). See Chapter I for further information about verification methods. LDSS do not provide verification of eligibility to providers.

Assistance to Patients Possibly Eligible for Benefits

If a patient is unable to pay for services rendered, the provider may refer the patient or the patient's authorized representative to the LDSS in the locality in which the applicant resides or to the Cover Virginia Call Center at 1-855-242-8282 for an application for health care coverage. The LDSS or Cover Virginia will notify the patient of eligibility or ineligibility. Medicaid assumes no financial responsibility for services rendered prior to the effective date of a member's eligibility. The effective date of Medicaid eligibility may be retroactive up to three months prior to the month in which the application was filed, if the patient was eligible during the retroactive period. Once a patient is found eligible, providers may bill Medicaid for covered services, and upon receipt of payment from Medicaid, must reimburse the patient for the out-of-pocket expenses; Medicaid does not reimburse members for out-of-pocket expenses.

Medicaid Applications -- Authorized Representative Policy

Medicaid eligibility requirements are strict and require an applicant or someone conducting business on his or her behalf to attest to citizenship or alien status, declare all income and assets, and make assignment of insurance and medical support benefits. In order to accurately determine eligibility, LDSS must ensure that an individual who files an application or someone conducting business on behalf of the applicant has full knowledge of the applicant’s situation and can provide correct information.

A Medicaid applicant must sign the application form unless the application is filed and signed by the applicant’s legal guardian or conservator, attorney-in-fact, or other person who is authorized to apply on the applicant’s behalf. If the applicant is unable to sign his or her name but can make a mark, the mark must be designated “his/her mark” and witnessed by one person.

A child under age 18 cannot legally sign a Medicaid application for himself or herself unless he or she is legally emancipated from his or her parents. If a child is not legally emancipated, his or her parent or legal guardian, an authorized representative designated by the parent or legal guardian,

or a caretaker relative with whom the child lives must sign the application. Exception: A minor child under 18 years of age may apply for Medicaid on behalf of his or her own child.

A legally competent individual age 18 or older may authorize anyone age 18 or older to file a Medicaid application on his or her behalf provided that the authorization is in writing, identifies the individual or organization authorized to conduct business on his or her behalf, and is signed by the individual giving the authorization.

When an individual has been determined by a court to be legally incompetent or legally incapacitated, the individual's legally appointed guardian or conservator is the individual's authorized representative and can apply for Medicaid on the individual's behalf. If an individual does not have a legal guardian or authorized representative and is mentally unable to sign an application or designate a representative, the individual's spouse will be considered the authorized representative for Medicaid purposes. In situations where the individual is not married, is estranged from his or her spouse, or the spouse is unable to represent him or her, a relative of the individual who is willing to take responsibility for the individual's Medicaid business may be considered his or her authorized representative. Relatives who may be considered authorized representatives in this situation are, in the following order of preference: the individual's adult child; parent; adult sibling; adult niece or nephew; or adult aunt or uncle.

If it is determined that an individual cannot sign an application and does not have an attorney in-fact or authorized representative, a Medicaid application may be filed by someone other than an authorized person provided the individual's inability to sign the Medicaid application is verified by a written statement from the individual's doctor. The statement must indicate that the individual is unable to sign and file a Medicaid application because of his or her diagnosis or condition. The LDSS will pend the application until it can be appropriately signed if it is determined that court action has been initiated to have a guardian or committee appointed for the individual or until an Adult Protective Services investigation concludes that guardianship proceedings will not be initiated. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of an individual who cannot designate an authorized representative.

An application may be filed on behalf of a deceased person by his or her guardian or conservator, attorney-in-fact, executor or administrator of his or her estate, surviving spouse, or a surviving family member, in the following order of preference: adult child, parent, adult sibling, adult niece or nephew, or adult aunt or uncle. The application must be filed within a three-month period subsequent to the month of the individual's death. Medicaid coverage can be effective no earlier than three months prior to the application month. Under no circumstances can an employee of, or an entity hired by, a medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Non-Medicaid Patient Relationship

Medicaid-eligible members who elect to be treated as private patients or who decline to verify their Medicaid eligibility with providers will be treated as private pay patients by the provider and by DMAS. Providers are required to furnish supporting documentation whenever patients fall into either of these categories.

Newborn Infant Eligibility

All newborn days, including claims for “well babies,” must be submitted separately. “Well baby” days cannot be processed as part of the mother’s per diem, and no information related to the newborn must appear on the mother’s claim.

A newborn is automatically considered eligible for Medicaid or FAMIS through age 1 year if the newborn’s mother was eligible for full coverage Medicaid or enrolled in FAMIS or FAMIS MOMS at the time she gave birth. A medical assistance application must be filed for any child whose mother was not eligible for Medicaid or enrolled in FAMIS/FAMIS MOMS at the time of the child’s birth.

An easy, streamlined way for hospitals to report the birth of the newborn is through the Medicaid Web Provider Portal www.virginiamedicaid.dmas.virginia.gov under the link “E213”. Any hospital staff that have approval from their hospital and have access to the portal may report the newborn’s birth and receive the newborn’s Member ID within 2 business days via email. The provider can verify newborn eligibility from the card using two other identification keys, including name, social security number, and the date of birth. These can be used to access MediCall, the verification vendors, and the web-based system, ARS.

See Chapter I: General Information for more information on eligibility verification.

Medicaid Eligibility for Hospice Services

To be eligible to elect hospice as a Medicaid benefit, an individual must be entitled to Medicaid benefits and be certified as terminally ill. "Terminally ill" is defined as having a medical prognosis that life expectancy is six months or less. If the individual is eligible for Medicare as well as Medicaid, the hospice benefit must be elected or revoked concurrently under both programs.

Guidelines on Institutional Status

Federal regulations in 42 CFR 435.1009 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution, and
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. A psychiatric residential treatment facility for children and adolescents is an IMD. An Intermediate Care Facility for the Intellectually Disabled (ICF-ID) is not an IMD.

Inmates of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated adults; and

- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid. The following are ineligible public institutions:

- public residential institutions with more than 16 beds
- residential facilities located on the grounds of, or adjacent to, a public institution with more than 16 beds.

Incarcerated Individuals

Incarcerated individuals (adults and juveniles) who are hospitalized can be eligible for Medicaid payment limited to services received during an inpatient hospitalization of 24 hours or longer, provided they meet all other Medicaid eligibility requirements.

Incarcerated individuals include:

- individuals under the authority of the Virginia Department of Corrections (DOC) or Virginia Department of Juvenile Justice (DJJ), and
- individuals held in regional and local jails, including those on work release.

Individuals are not eligible for full benefit Medicaid coverage while they are living in a correctional facility, regional or local jail or juvenile facility.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and can only be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

Once an individual is released from the correctional facility, he can be enrolled in full benefit Medicaid, provided he meets all Medicaid eligibility requirements.

Juveniles

In determining whether a juvenile (individual under age 21 years) is incarcerated, the federal Medicaid regulations distinguish between the nature of the detention, pre- and postdisposition situations, and types of facilities.

a. Prior to Court Disposition

The following juveniles can be eligible for Medicaid payment limited to services received during an inpatient hospitalization.

- Juvenile who is in a detention center due to criminal activity
- Juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution and can only be eligible for Medicaid payment limited to inpatient hospitalization. A list of secure detention facilities in Virginia is available on the Department of Juvenile Justice's web site: http://www.djj.virginia.gov/Residential_Programs/Secure_Detention/pdf/Detention_Home_Contacts_02242011rev.pdf.

If they go to a non-secure group home, they can be eligible for Medicaid or FAMIS because a non-secure group home is not a detention center. A juvenile who is in a detention center due to care, protection or in the best interest of the child can be eligible for full benefit Medicaid or Family Access to Medical Insurance Security (FAMIS) coverage.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible for full-benefit Medicaid if he/she is a resident of an ineligible public residential facility. He can be eligible for Medicaid coverage limited to inpatient hospitalization if he is admitted to a medical facility for inpatient services.

Who is Not an Inmate of a Public Institution

An individual is NOT an inmate of a public institution if:

- The individual is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- The individual is in a public institution for a temporary period pending other arrangements appropriate to his needs. Individuals in public institutions for a temporary period include:
  - individuals admitted under a TDO
  - individuals arrested then admitted to a medical facility
  - inmates out on bail
  - individuals on probation (including a juvenile on conditional probation or probation in a secure treatment center), parole, or conditional release
  - juveniles in a detention center due to care, protection or in their best interest.

Member Appeals

The Code of Federal Regulations at 42 CFR §431, Subpart E, and the Virginia Administrative Code at 12VAC30-110-10 through 12VAC30-110-370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid member or by an authorized

representative on behalf of the member. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act on a request for services within required timeframes may be appealed. Members who are enrolled in an MCO may appeal to the MCO or directly to DMAS. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, or within 10 days of the date the notice of action was sent, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the member may be expected to repay DMAS for all services received during the appeal period. For this reason, the member may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If services are continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Member appeals must be requested in writing and postmarked or submitted within 30 days of receipt of the notice of adverse action. The member or his authorized representative may complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, or by calling (804) 371-8488.

If the member is not able to get the form, he may write a letter. The letter must include the name of the person whose request for benefits was denied, reduced, or cancelled. Also, the letter must include the person’s date of birth, social security number, case number, the agency that took the action, and the date of the action.

A copy of the notice or letter about the adverse action should be included with the appeal request. The appeal request must be sent to the:

Appeals Division
Department of Medical Assistance Services
600 E. Broad Street, 6th Floor
Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 452-5454

The Appeals Division will notify members of the date, time and location of the hearing if the appeal is valid and a hearing is granted. The hearing will be conducted by a DMAS Hearing Officer. Most hearings will be done by telephone.

The Hearing Officer’s decision is the final administrative decision by DMAS. If the member does not agree with the Hearing Officer’s decision, he/she may appeal it directly to the circuit court in the city or county of residence.

Covered Services and Limitations (LEA)

INTRODUCTION

The Individuals with Disabilities Education Act (IDEA) requires local education agencies

(LEAs) to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While LEAs are financially responsible for educational services, in the case of a Medicaid or Children's Health Insurance Program (CHIP)-enrolled student, state agencies that administer Medicaid and CHIP programs may reimburse part of the costs of providing the services identified in the student's IEP if they are covered under the state's plan for medical assistance and determined to be medically necessary by a qualified professional.

Medicaid programs may also reimburse LEAs for costs associated with providing the federally-required screening services that are part of the early and periodic screening, diagnostic and treatment services (EPSDT) benefit for Medicaid-enrolled students. See the EPSDT Supplemental Provider Manual available online at the Virginia Medicaid Web Portal for guidance on DMAS-covered well child visits and EPSDT screenings at virginiamedicaid.dmas.virginia.gov.

LEA school-based services described in this chapter are covered by the Virginia Department of Medical Assistance Services (DMAS) for Medicaid-enrolled students, and for students enrolled in Virginia's Family Access to Medical Insurance Security (FAMIS) program. (Note: Virginia's CHIP program is known as the FAMIS program.). Individual service providers of LEA school-based services must meet the qualifications described in Chapter II, "Provider Participation Requirements." Providers meeting these requirements are referred to throughout this chapter as "DMAS qualified providers."

DMAS Reimbursable Services Provided by Local Education Agencies

Evaluations for DMAS-covered services, and ongoing services, when authorized through a Medicaid or FAMIS-enrolled student's Individualized Education Program (IEP), are carved out of the DMAS managed care delivery system and claims for payment are processed on a fee-for-service basis. Covered services include:

- Physical therapy (PT)
- Occupational therapy (OT)
- Speech-language pathology (SLP)
- Audiology
- Nursing
- Psychiatry, Psychology, and Mental Health
- Personal Care
- Medical Evaluations
- Specialized Transportation

- Service-specific Evaluations

Non-School-Related Services Received from Non-School Providers

Many children enrolled in special education who receive LEA school-based services via their IEP also receive Medicaid or FAMIS covered services outside of special education (e.g., a student receives outpatient physical therapy services from a private provider as ordered by their personal physician). **A child's Medicaid or FAMIS eligibility for and coverage of services received from non-school providers outside of their IEP are not impacted by the fact that the child receives Medicaid/FAMIS-reimbursable services under the IEP.**

Eligibility Requirements (LEA)

For an LEA to receive reimbursement for providing LEA school-based services, the student receiving the service must be currently enrolled in Medicaid, FAMIS, FAMIS Plus, or FAMIS MOMS. The LEA Provider Manual outlines the requirements that LEAs must meet in order to bill for services provided to eligible students under the age of 21. **LEAs should refer to the Rehabilitation Manual, Psychiatric Services Manual, and Physicians/Practitioners Manual available on the Virginia Medicaid Web Portal (www.virginiamedicaid.dmas.virginia.gov) for guidance on serving students eligible for special education who are over the age of 21.** Students may have frequent changes to their type of coverage, so eligibility should be verified at each point of service.

Checking Eligibility and Enrollment on the Virginia Medicaid Web Portal

The Virginia Medicaid Web Portal is used by authorized LEA Medicaid billing coordinators to access a student's Medicaid or FAMIS information for purposes of checking eligibility and enrollment status, or for checking the status of a service claim. **LEA billing and service provider staff must follow all applicable state and federal laws and regulations concerning access to student information.**

First-time Registrations to the Virginia Medicaid Web Portal

First-time users can navigate to the Virginia Medicaid Web Portal and establish a user ID and password. Note: portal registration is different from provider enrollment. A service provider may enroll with DMAS without being registered to access the portal, and an

individual (e.g., school Medicaid coordinator) can register with the portal without being an enrolled service provider. DMAS recommends that all enrolled service providers register through the portal in order to facilitate the enrollment process, receive important DMAS announcements via email, and access provider information and training materials. Answers to the most common questions regarding the registration process may be found within the Web registration reference materials available on the Web Portal. If further assistance is required, however, please contact the Virginia Medicaid Web Support Help Desk (toll free) at 1-866-352-0496.

Eligibility Verification

See Chapter I of this manual for information on checking a student's eligibility for Medicaid or FAMIS.

Medical Necessity (LEA)

Under DMAS' State Plan for Medical Assistance, approved by the Centers for Medicare and Medicaid Services (CMS), covered School-Based Services must be necessary to "correct or ameliorate defects of physical or mental illnesses or conditions". Identification of illnesses or conditions, and services necessary to correct or ameliorate their effects is done by practitioners qualified to make those determinations within their licensed scope of practice.

Services provided by or supervised by a licensed nurse must be based on an active, written plan of care that is based on a written order from a physician, physician assistant or nurse practitioner. This order must be recertified on an annual basis. (Please note the physician, physician assistant or nurse practitioner does not have to be a part of the IEP team to order these services.)

CRITERIA FOR COVERED SERVICES (GENERAL)

Medical and Service-Specific Evaluations

DMAS covers evaluations performed by a DMAS-qualified provider, acting within the scope of his or her license. This includes Medical Evaluations performed by a physician, nurse practitioner or physician assistant, and evaluations performed by specific covered service-providing disciplines (PT, OT, SLP, Audiology or Psychology/Mental Health). In order to bill for evaluations, the evaluation, listed as a service itself (e.g., "PT evaluation"), or the service type providing the evaluation (e.g., simply "PT") must be listed or referenced in the student's written IEP plan.

School-based Services Provided in the Student's Home

LEAs may bill for covered services provided in the student's home by LEA-paid employees or contractors. The service must be included in the IEP and all other conditions for coverage must be met.

Consultation Services

DMAS does not cover professional consultations (interactions between two or more providers in regards to the student's care).

Professional Therapies

The following guidelines are designed to assist with determining medical necessity for "rehabilitation and habilitation" professional services (therapy services) that are billable to DMAS by LEAs. Rehabilitation and habilitation services include PT, OT, SLP and audiology.

A service may not be billed as a therapy service if it does not require the skill level of a qualified therapist to carry out the activity. For example, DMAS will not reimburse for a professional service performed by a qualified therapist working with a student on a particular IEP goal if the goal can be met by a trained personal care assistant providing a personal care service.

Therapy Definitions

To be covered, therapy services must meet criteria for rehabilitation or habilitation services.

- *Rehabilitation*: Necessary medical services needed for improving or restoring functions which have been impaired by illness/disability/injury.

- *Rehabilitation Therapy to Ameliorate Symptoms or Prevent Disease Progression*:

  Necessary medical services to ameliorate (to make better or more tolerable) disease symptoms or to prevent disease progression.

- *Habilitation*: Necessary medical services needed to assist a student in developing new skills or functions that they are incapable of developing on their own. Example: A student who was never able to walk and now has gained the ability to walk. (Habilitation services are only covered for students under the age of 21.)

Maintenance level services do not require the skill level of a qualified therapist acting within the scope of his or her license, and typically do not meet the definitions of rehabilitation or habilitation services. These services, however, may be medically necessary for the student to maintain current level of function and avoid more intensive services. DMAS reimburses for maintenance level services performed by a personal care assistant (PCA) in the schools when supervised by a DMAS qualified provider acting within the scope of his or her license (see Personal Care Services section).

ADDITIONAL GUIDANCE FOR THERAPY SERVICES

Definition of a Visit

A visit is defined as a meeting or interaction between the student and one or more service provider(s) for purposes of providing LEA school-based, covered services. Visits are not defined by increments of time or by a particular location. The furnishing of one or more services by a particular provider on a particular day or at a particular time of day constitutes a visit. For example:

- An SLP provider furnishes one or more covered services to a single student during a single meeting or interaction: this constitutes one visit.
- An OT provider furnishes one or more covered services during two distinctly separate meetings or interactions that occur in the same day (e.g., a morning session and an afternoon session): this constitutes two visits.
- A PT provider and an occupational therapy provider furnish different covered services to a single student on the same day at different times: this constitutes two visits.
- A PT provider and an OT provider, working together on the same goal, furnish a covered service for a student during a single meeting (e.g., two therapists are required to perform a single procedure). This constitutes a single visit.

Some therapy services may be provided in a group format. DMAS will reimburse for covered group therapy services for covered students when the group consists of at least two participants. Providers must consult their individual practice guidelines for appropriate maximum group size limits, which may vary depending on specialty, modality and treatment goals. In these instances each student is receiving a separate “visit”, and each visit may be

billed.

Physical Therapy

PT services may be reimbursed by DMAS under the following conditions:

- The services must be included in the student's IEP and must be directly and specifically related to an active written plan of care developed by a DMAS qualified physical therapist;
- The services must be of a level of complexity and sophistication, or the condition of the student must be of a nature that the services can only be performed by a DMAS-qualified physical therapy provider as defined in Chapter II of this manual;
- Based on the assessment made by the licensed PT, services must be provided with the expectation that the condition of the student will improve in a reasonable and generally predictable period of time, or the services are necessary to ameliorate the condition or slow the disease progression;
- The services must be provided to address an established diagnosis using the current International Classification of Diseases (ICD) manual; and
- The services must be specific and provide effective treatment for the student's condition in accordance with accepted standards of medical practice.

The licensed PT must develop a plan of care; however, the implementation of the plan may be carried out by a licensed physical therapy assistant (PTA) as defined in Chapter II of this manual.

Note: Covered physical therapy services must be provided by DMAS-qualified physical therapy providers. These services may not be performed by supportive personnel (e.g., unlicensed service providers including physical therapy aides, personal care assistants, nursing staff, volunteers). Please refer to Personal Care Assistant Services section of this chapter for more information on covered services performed by these individuals.

Occupational Therapy

Occupational therapy services may be reimbursed by DMAS under the following conditions:

- The services must be included in the student's IEP and must be directly and

specifically related to an active written plan of care developed by a licensed occupational therapist who is also a DMAS-qualified provider;

- The services must be of a level of complexity and sophistication or the condition of the student must be of a nature that the services can only be performed by a DMAS-qualified occupational therapy provider as defined in Chapter II of this manual;

- Based on the assessment made by the licensed occupational therapist, services must be provided with the expectation that the condition of the student will improve in a reasonably and generally predictable period of time, or the services are necessary to ameliorate the condition or reduce disease progression;
- The services must be in association with a specific diagnosis in the current ICD manual; and
- The services must be specific and provide effective treatment for the student's condition in accordance with accepted standards of medical practice.

A licensed occupational therapist must develop the plan of care; however, the implementation of the plan may be carried out by a licensed occupational therapy assistant (OTA) as defined in Chapter II of this manual.

Note: Covered occupational therapy services must be provided by DMAS-qualified occupational therapy providers. These services may not be performed by supportive personnel (e.g., unlicensed service providers (e.g., occupational therapy aides, personal care assistants, nursing staff, and volunteers). Please refer to Personal Care Assistant Services section of this chapter for more information on covered services performed by these individuals.

Speech-Language Therapy

Speech-language therapy services are services provided to a student that meet all of the following conditions:

- The services must be included in the student's IEP and must be directly and

specifically related to an active written plan of care developed by a licensed master's level SLP who is also a DMAS-qualified provider;

- The services must be of a level of complexity and sophistication or the condition of the student must be of a nature that the services can only be performed by a DMAS-qualified speech-language therapy provider as defined in Chapter II of this manual;

- Based on the assessment made by the DMAS qualified provider, services must be provided with the expectation that the condition of the student will improve in a reasonable and generally predictable period of time, or the services are necessary to ameliorate or reduce the disease progression;

- The services must be in association with a specific diagnosis in the current ICD manual; and

- The services must be specific and provide effective treatment for the student's condition in accordance with accepted standards of medical practice.

Only a DMAS-qualified licensed master's level SLP can develop a plan of care. The implementation of the plan may be carried out by a qualified DMAS provider of speech and language pathology services, which includes licensed non-master's level SLPs working under the supervision of a licensed masters-level SLP.

Note: Covered speech-language therapy services must be provided by DMAS-qualified speech-language therapy providers. These services may not be performed by supportive personnel (e.g., unlicensed service providers such as speech-language therapy aides, personal care assistants, nursing staff, and volunteers). Please refer to Personal Care Assistant Services section of this chapter for more information.

Audiological Services

Audiological services are services provided to a student that meet all of the following conditions:

- The services must be included in the IEP and must be directly and specifically related to an active written plan of care designed by a licensed Audiologist who is also a DMAS qualified provider;
- The services must be of a level of complexity and sophistication or the condition of the student must be of a nature that the services can only be performed by a DMAS-qualified audiological provider as defined in Chapter II of this manual;
- The services must be provided with the expectation, based on the assessment made by the DMAS qualified provider, that the condition of the student will improve in a reasonable and generally predictable period of time, or the services must be necessary to improve symptoms or slow the disease progression;
- The services must be in association with a specific diagnosis in the current ICD manual; and
- The services must be specific and provide effective treatment for the student's condition in accordance with accepted standards of medical practice.

Only a licensed Audiologist as detailed in Chapter II of this manual can provide audiological services.

Note, there is no provision for DMAS to reimburse for audiology services provided by unlicensed student interns, even if they are working under the direct supervision of a licensed provider. DMAS does not reimburse for hearing screenings provided by LEA providers.

ADDITIONAL GUIDANCE FOR PSYCHIATRY, PSYCHOLOGY AND MENTAL HEALTH SERVICES

Psychiatry, psychology and mental health services must meet the following conditions:

- Services must be included in the IEP; and
- Services must be of a level of complexity and sophistication, or the condition of the student must be of a nature that the services can only be performed by a qualified psychiatric, psychological or mental health provider as defined in Chapter II of this manual.

On-going psychiatry, psychology and mental health services must also:

- Be based on an evaluation that includes a mental status examination;
- Be directly and specifically related to an active written plan (e.g., plan of treatment)

developed by a DMAS qualified psychiatric, psychological or mental health provider, as defined in Chapter II of this manual;

- Be associated with a specific diagnosis based on the current ICD manual;
- Be required in order to:
    - Sustain behavioral or emotional gains or to restore cognitive functional levels, which have been impaired; or
    - Improve emotional or behavioral symptoms that are impacting attention and concentration, the ability to learn, or the ability to participate in educational or social activities;
- Services must be specific and provide effective treatment for the student's condition in accordance with accepted standards of medical practice.

Criteria for Nursing Services (LEA)

Skilled nursing services are to be rendered in accordance with the licensing standards and criteria of the Virginia Board of Nursing. Services are to be performed by a Virginia-licensed registered nurse (RN), or Virginia licensed practical nurse (LPN) working under the supervision of an RN, in accordance with Board of Nursing regulations.

Skilled nursing services are those that are deemed medically necessary to assess, monitor, and provide medical interventions to treat or maintain the student's medical condition. The services must be of a level of complexity and sophistication or the condition of the student must be of a nature that the services can only be performed by an RN, or an LPN supervised by an RN. Examples of skilled nursing services include tube feedings, dressing changes, maintaining patient airways, medication administration/monitoring and urinary catheterizations.

Services that do not require the skill level of a licensed nurse, as described above, may not be billed as skilled nursing services even when performed by a licensed nurse, although an RN may supervise such tasks performed by non-licensed personnel.

If the provision of a billable service that does not require the skill level of a licensed nurse coincides with the provision of a skilled nursing service, the licensed nurse may bill for both services (e.g., personal care service).

Note, the ordering physician, physician assistant or nurse practitioner does not have to be a part of the IEP team to order nursing services, although the need for the services must be listed or referenced in the IEP in order to be reimbursed.

Service Units

The unit of service for nursing is 15 minutes. Time spent by an RN or LPN in delivering authorized nursing services to a covered student, as a part of the student's IEP, may be submitted to DMAS for reimbursement. The approved nursing units may include both nursing and personal care time if the personal care tasks are incidental to the nursing care. Payment of nursing services is limited to 6.5 hours per day or 26 units per day.

PERSONAL CARE ASSISTANCE SERVICES

All of the following criteria must be met in order for personal care assistant services to be determined appropriate in the local education agency setting and reimbursable by DMAS:

- The service must be included in the IEP;
- Training and supervision must be provided by the appropriate, discipline-specific DMAS qualified provider of the services as listed in the plan of care.

Services may include, but are not limited to the following:

- Assistance with ADLs (e.g., bathing, dressing, toileting, eating/feeding).
- Assistance with meal preparation for the individual.
- Supervision related to a health condition (stand-by assistance).
- Maintenance level services (e.g., student positioning or transfer assistance, performing exercises to maintain range of motion).
- Assistance with adaptive behavioral functioning performed as part of a written behavior modification plan developed by a licensed mental health provider.
- Supervision to ensure a student's safety while using non-emergency specialized transportation to travel to or from a site where another DMAS-covered, IEP-authorized service is being performed. The other service must be billed to and reimbursed by DMAS in order for the personal care assistance services to be covered.

Note, some students that are eligible for or are receiving covered, school-based, IEP-authorized personal care services may also receive personal care services outside of the school setting through a separate DMAS benefit (e.g., Medicaid Home and Community Based Services waiver, Medicaid EPSDT).

Service Units

The unit of service for personal care is 15 minutes. The LEA may only bill for one personal care service per unit of time per student, regardless of the number of personal care assistants required to complete the service for that student.

An LEA may bill for up to six personal care transportation assistance "visits" performed by a single assistant during a single trip.

Non-Covered Services

- General supervision for non-medical reasons (e.g., toileting for two year old); and
- Performance of tasks for the sole purpose of assistance with completion of educational assignments.
- General supervision that does not require the skill of a trained personal care assistant supervised by a licensed provider.

CRITERIA FOR MEDICAL EVALUATION SERVICES

LEAs may bill for medical evaluation services when performed by a physician (see 42 CFR §440.50) or by a non-physician licensed practitioner acting within their scope of practice under State law (see "medical or other remedial care provided by licensed practitioners" at 42 CFR §440.60). Persons performing these services must be DMAS qualified providers as defined in Chapter II of this manual acting within the scope of their practice.

Reimbursable medical evaluation services include:

- Assessment of a student's medical needs in order to determine if he or she is eligible for special education services, if the student is subsequently enrolled in special education and the assessment is documented in the IEP;
- Review of a student's initial IEP to confirm the medical necessity for the medical/mental health related services recommended by the IEP team;
- Annual review of a student's IEP to confirm continuing medical necessity for the medical/mental health related services recommended by the IEP team;
- Review of additional documents related to a student's medical/mental health status either for consultative purposes or to determine medical necessity for services;
- Participating in meetings with IEP providers and/or family members to provide

medical input concerning a student's disability and medical/mental health-related services needed;

- Coordinating LEA-based medical/mental health related services with those rendered outside the school setting. For example, conferring with a student's primary care physician about medication needs; and
- Completion of record documentation activities relative to the IEP.

Criteria for Specialized Transportation (LEA)

Non-emergency specialized transportation provided by a local education agency is a covered service on days when the student receives another DMAS covered service documented in the IEP. The other service must be billed to and reimbursed by DMAS. Specialized transportation must also be included in the student's IEP in order to be covered.

Specialized transportation enables the student to receive the DMAS covered service. Specialized transportation may involve a trip from the student's home to the LEA site and the return trip, or from the LEA site or student's home to an LEA contracted provider site, and the return trip. Specialized transportation must be rendered by local education agency personnel or contractors.

Specialized transportation refers to a specially equipped school vehicle that is designed, equipped, or modified to accommodate students with special needs. (See 8VAC20-70-10 for definitions of "school bus" and specially equipped school bus.)

Note, LEA specialized transportation services are not delivered through the Virginia Medicaid Non-Emergency Transportation (NET) Brokerage program.

TELEMEDICINE

Telemedicine is a means of providing covered services through the use of two-way, real time interactive electronic communication between the student and the DMAS-qualified provider located at a site distant from the student. This electronic communication must include, at a minimum, the use of audio and video equipment.

The following school-based services may be provided via telemedicine: PT, OT, speech and language, psychological and mental health, and medical evaluation services. DMAS does not require the presence of a paid staff person with the student at the time of the service, however, a paid staff person must be present and supervise the visit if the LEA submits a claim for the "originating site fee".

Reference the "DMAS Telehealth Manual Supplement" for additional details on DMAS's requirements for telemedicine.

CLAIM INQUIRIES & RECONSIDERATION (LEA)

For inquiries concerning covered benefits, specific billing procedures or questions regarding Virginia Medicaid policies and procedures call (800) 552-8627.

Billing Instructions (LEA)

INTRODUCTION

The purpose of this chapter is to explain the documentation procedures for billing the Virginia Department of Medical Assistance Services (DMAS) for Medicaid covered services.

Two major areas are covered in this chapter:

General Information - This section contains information about the timely filing of claims, claim inquiries, and supply procedures.

Billing Procedures - Instructions are provided on the completion of claim forms, submitting adjustment requests, and additional payment services.

DIRECT DATA ENTRY (DDE)

As part of the 2011 General Assembly Appropriation Act - 300H which requires that all new providers bill claims electronically and receive reimbursement via Electronic Funds Transfer (EFT) no later than October 1, 2011 and existing Medicaid providers to transition to electronic billing and receive reimbursement via EFT no later than July 1, 2012, DMAS has implemented the Direct Data Entry (DDE) system. Providers can submit claims quickly and easily via the Direct Data Entry (DDE) system. DDE will allow providers to submit Professional (CMS-1500), Institutional (UB-04) and Medicare Crossover claims directly to DMAS via the Virginia Medicaid Web Portal. Registration through the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQs can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider.

ELECTRONIC FILING REQUIREMENTS (LEA)

Effective March 30, 2012, DMAS was fully compliant with 5010 transactions and no longer accepted 4010 transactions after March 30, 2012.

The Virginia MMIS accommodates the following EDI transaction according to the specification published in the Companion Guide version 5010 – this transaction pertains to Local Education Agency billing.

- 837 - Professional Health Care Claim or Encounter (5010)

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

All 5010/D.0 Companion Guides are available on the web portal:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/EDICompanionGuides.

The contact for EDI Support is **(866)-352-0766**.

Timely Filing

The Medical Assistance Program regulations require the prompt submission of all claims. Virginia Medicaid is mandated by federal regulations [42 CFR § 447.45(d)] to require the initial submission of all claims (including accident cases) within 12 months from the date of service. Providers are encouraged to submit billings within 30 days from the last date of service or discharge. Federal financial participation is not available for claims, which **are not** submitted within 12 months from the date of the service. Submission is defined as actual, physical receipt by DMAS. In cases where the actual receipt of a claim by DMAS is undocumented, it is the provider's responsibility to confirm actual receipt of a claim by DMAS within 12 months from the date of the service reflected on a claim. If billing electronically and timely filing must be waived, submit the DMAS-3 form with the appropriate attachments. The DMAS-3 form is to be used by electronic billers for attachments. (See Exhibits) Medicaid is not authorized to make payment on these late claims, except under the following conditions:

Retroactive Eligibility - Medicaid eligibility can begin as early as the first day of the third month prior to the month of application for benefits. All eligibility requirements must be met within that time period. Unpaid bills for that period can be billed to Medicaid the same as for any other service. If the enrollment is not accomplished in a timely way, billing will be handled in the same manner as for delayed eligibility.

Delayed Eligibility - Medicaid may make payment for services billed more than 12 months

from the date of service in certain circumstances. Medicaid denials may be overturned or other actions may cause eligibility to be established for a prior period. Medicaid may make payment for dates of service more than 12 months in the past when the claims are for an enrollee whose eligibility has been delayed. It is the provider's obligation to verify the patient's Medicaid eligibility. Providers who have rendered care for a period of delayed eligibility will be notified by a copy of a letter from the local department of social services which specifies the delay has occurred, the Medicaid claim number, and the time span for which eligibility has been granted. The provider must submit a claim on the appropriate Medicaid claim form within 12 months from the date of the notification of the delayed eligibility. A copy of the "signed and dated" letter from the local department of social services indicating the delayed claim information must be attached to the claim.

Denied claims – Denied claims must be submitted and processed **on or before thirteen months from date of the initial denied claim where the initial claim was filed within the 12 months limit to be** considered for payment by Medicaid. The procedures for resubmission are:

- Complete invoice as explained in this billing chapter.
- **Attach** written documentation to justify/verify the explanation. This documentation may be continuous denials by Medicaid or any dated follow-up correspondence from Medicaid showing that the provider has actively been submitting or contacting Medicaid on getting the claim processed for payment. Actively pursuing claim payment is defined as documentation of contacting DMAS at least every six months. Where the provider has failed to contact DMAS for six months or more, DMAS shall consider the resubmission to be untimely and no further action shall be taken. If billing electronically and waiver of timely filing is being requested, submit the claim with the appropriate attachments. (The DMAS-3 form is to be used by electronic billers for attachments. See exhibits).

Accident Cases - The provider may either bill Medicaid or wait for a settlement from the responsible liable third party in accident cases. However, all claims for services in accident cases must be billed to Medicaid within 12 months from the date of the service. If the provider waits for the settlement before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursement.

Other Primary Insurance - The provider should bill other insurance as primary. However, all claims for services **must be billed to Medicaid within 12 months from the date of the service.** If the provider waits for payment before billing Medicaid and the wait extends beyond 12 months from the date of the service, Medicaid shall make no reimbursements. If payment is made from the primary insurance carrier after a payment from Medicaid has been made, an adjustment or void should be filed at that time.

Other Insurance - The member can keep private health insurance and still be covered by Medicaid or FAMIS Plus. The other insurance plan pays first. Having other health insurance does not change the co-payment amount that providers can collect from a Medicaid member. For members with a Medicare supplemental policy, the policy can be suspended

with Medicaid coverage for up to 24 months while the member has Medicaid without penalty from their insurance company. The members must notify the insurance company. The member must notify the insurance company within 90 days of the end of Medicaid coverage to reinstate the supplemental insurance.

Submit the claim in the usual manner by mailing the claim to billing address noted in this chapter.

BILLING INVOICES (LEA)

The requirements for submission of physician billing information and the use of the appropriate claim form or billing invoice are dependent upon the type of service being rendered by the provider and/or the billing transaction being completed. Listed below is the billing invoice to be used:

- Health Insurance Claim Form, CMS-1500 (02-12)

If submitting on paper, the requirement to submit claims on an original CMS-1500 claim form is necessary because the individual signing the form is attesting to the statements made on the reverse side of this form; therefore, these statements become part of the original billing invoice.

Medicaid reimburses providers for the coinsurance and deductible amounts on Medicare claims for Medicaid members who are dually eligible for Medicare and Medicaid. However, the amount paid by Medicaid in combination with the Medicare payment will not exceed the amount Medicaid would pay for the service if it were billed solely to Medicaid.

REQUESTS FOR BILLING MATERIALS

Health Insurance Claim Form CMS-1500 (02-12) and (UB-04)

The CMS-1500 (02-12) and CMS-1450 (UB-04) are universally accepted claim forms that is required when billing DMAS for covered services. The form is available from form printers and the U.S. Government Printing Office. Specific details on purchasing these forms can be obtained by writing to the following address:

U.S. Government Print Office

Superintendent of Documents

Washington, DC 20402

(202) 512-1800 (Order and Inquiry Desk)

Note: The CMS-1500 (02-12) will not be provided by DMAS.

REMITTANCE/PAYMENT VOUCHER

DMAS sends a check and remittance voucher with each weekly payment made by the Virginia Medical Assistance Program. The remittance voucher is a record of approved, pended, denied, adjusted, or voided claims and should be kept in a permanent file for five (5) years.

The remittance voucher includes an address location, which contains the provider's name and current mailing address as shown in the DMAS' provider enrollment file. In the event of a change-of-address, the U.S. Postal Service **will not** forward DMAS payment checks and vouchers to another address. Therefore, it is recommended that DMAS' Provider Enrollment and Certification Unit be notified in sufficient time prior to a change-of-address in order for the provider files to be updated.

Providers are encouraged to monitor the remittance vouchers for special messages since they serve as notifications of matters of concern, interest and information. For example, such messages may relate to upcoming changes to DMAS policies and procedures; may serve as clarification of concerns expressed by the provider community in general; or may alert providers to problems encountered with the automated claims processing and payment system.

ANSI X12N 835 HEALTH CARE CLAIMS PAYMENT ADVICE

The Health Insurance Portability and Accountability Act (HIPAA) requires that DMAS comply with the electronic data interchange (EDI) standards for health care as established by the Secretary of Health and Human Services. The 835 Claims Payment Advice transaction set is used to communicate the results of claim adjudication. DMAS will make a payment with electronic funds transfer (EFT) or check for a claim that has been submitted by a provider (typically by using an 837 Health Care Claim Transaction Set). The payment detail is electronically posted to the provider's accounts receivable using the 835.

In addition to the 835 the provider will receive an unsolicited 277 Claims Status Response for the notification of pending claims.

Claim Inquiries and Reconsideration

Inquiries concerning covered benefits, specific billing procedures, or questions regarding Virginia Medicaid policies and procedures should be directed to:

Customer Services
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

A review of additional documentation may sustain the original determination or result in an approval or denial.

Telephone Numbers

1-804-786-6273	Richmond Area and out-of-state long distance
1-800-552-8627	In-state long-distance (toll-free)

Member verification and claim status may be obtained by telephoning:

1-800- 772-9996	Toll-free throughout the United States
1-800- 884-9730	Toll-free throughout the United States
1-804- 965-9732	Richmond and Surrounding Counties
1-804- 965-9733	Richmond and Surrounding Counties

Member verification and claim status may also be obtained by utilizing the Web-based Automated Response System. See Chapter I for more information.

ELECTRONIC FILING REQUIREMENTS

DMAS is fully compliant with 5010 transactions and will no longer accept 4010 transactions after March 30, 2012.

The Virginia MMIS will accommodate the following EDI transactions according to the specification published in the Companion Guide version 5010:

270/271 Health Insurance Eligibility Request/ Response Verification for Covered Benefits (5010)

276/277 - Health Care Claim Inquiry to Request/ Response to Report the Status of a Claim (5010)

277 - Unsolicited Response (5010)

820 - Premium Payment for Enrolled Health Plan Members (5010)

834 - Enrollment/ Disenrollment to a Health Plan (5010)

835 - Health Care Claim Payment/ Remittance (5010)

837 - Dental Health Care Claim or Encounter (5010)

837 - Institutional Health Care Claim or Encounter (5010)

837 - Professional Health Care Claim or Encounter (5010)

NCPDP - National Council for Prescription Drug Programs Batch (5010)

NCPDP - National Council for Prescription Drug Programs POS (5010)

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

Although not mandated by HIPAA, DMAS has opted to produce an Unsolicited 277 transaction to report information on pended claims.

For providers that are interested in receiving more information about utilizing any of the above electronic transactions, your office or vendor can obtain the necessary information at our fiscal agent's website: https://www.virginiamedicaid.dmas.virginia.gov.

CLAIMCHECK/CORRECT CODING INITIATIVE (CCI)

- Effective June 3, 2013, DMAS implemented the Medicaid National Correct Coding Initiative (NCCI) Procedure to Procedure (PTP) and Medically Unlikely Edits (MUE) edits. This implementation was in response to directives in the Affordable Care Act of 2010. These new edits will impact all Physicians, Laboratory, Radiology, Ambulatory Surgery Centers, and Durable Medical Equipment and Supply providers. The NCCI/ClaimCheck edits are part of the daily claims adjudication cycle on a concurrent basis. The current claim will be processed to edit history claims. Any adjustments or denial of payments from the current or history claim(s) will be done during the daily adjudication cycle and reported on the providers weekly remittance cycle. All NCCI/ClaimCheck edits are based on the following global claim factors: same member, same servicing provider, same date of service or the date of service is within established pre- or post-operative time frame. All CPT and HCPCS code will be subject to both the NCCI and ClaimCheck edits. Upon review of the denial, the provider can re-submit a corrected claim. Any system edits related to timely filing, etc. are still applicable.

- PTP Edits:

  CMS has combined the Medicare Incidental and Mutually Exclusive edits into a new PTP category. The PTP edits define pairs of CPT/HCPCS codes that should not be reported together. The PTP codes utilize a column one listing of codes to a column two listing of codes. In the event a column one code is billed with a column two code, the column one code will pay, the column two code will deny. The only exception to the PTP is the application of an accepted Medicaid NCCI modifier. **Note**: Prior to this implementation, DMAS modified the CCI Mutually Exclusive edit to pay the procedure with the higher billed charge. This is no longer occurring, since CMS has indicated that the code in column one is to be paid regardless of charge.

- MUE Edits:

  DMAS implemented the Medicaid NCCI MUE edits. These edits define for each CPT/HCPCS code the maximum units of service that a provider would report under most circumstances for a single member on a single date of service and by same servicing provider. The MUEs apply to the number of units allowed for a specific procedure code, per day. If the claim units billed exceed the per day allowed, the claim will deny. With the implementation of the MUE edits, providers must bill any bilateral procedure correctly. The claim should be billed with one unit and the 50 modifier. The use of two units will subject the claim to the MUE, potentially resulting in a denial of the claim. Unlike the current ClaimCheck edit which denies the claim and creates a claim for one unit, the Medicaid NCCI MUE edit will deny the entire claim.

- Exempt Provider Types

  DMAS has received approval from CMS to allow the following provider types to be exempt from the Medicaid NCCI editing process. These providers are: Community Service Boards (CSB), Federally Qualified Health Centers (FQHC) Rural Health Clinics (RHC), Schools and Health Departments. These are the only providers exempt from the NCCI/editing process. All other providers billing on the CMS 1500 will be subject to these edits.

- Service Authorizations:

  DMAS has received approval from CMS to exempt specific CPT/HCPCS codes which require a valid service authorization. These codes are exempt from the MUE edits however, they are still subject to the PTP and ClaimCheck edits.

- Modifiers:

  Prior to this implementation, DMAS allowed claim lines with modifiers 24, 25, 57, 59 to bypass the CCI/ClaimCheck editing process. With this implementation, DMAS now only allows the Medicaid NCCI associated modifiers as identified by CMS for the Medicaid NCCI. The modifier indicator currently applies to the PTP edits. The application of this modifier is determined by the modifier indicator of "1"or "0" in the listing of the NCCI PTP column code. If the column one, column two code combination has a modifier indicator of "1", a modifier is allowed and both codes will pay. If the modifier indicator is "0", the modifier is not allowed and the column two code will be denied. The MUE edits do not contain a modifier indicator table on the edit table. Per CMS, modifiers may only be applied if the clinical circumstances justify the use of the modifier. A provider cannot use the modifier just to bypass the edit. The recipient's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier. DMAS or its agent will monitor and audit the use of these modifiers to assure compliance. These audits may result in recovery of overpayment(s) if the medical record does not appropriately demonstrate the use of the modifiers.

  Modifiers that may be used under appropriate clinical circumstances to bypass an NCCI PTP edit include: E1 –E4, FA, F1 – F9, TA T1 – T9, LT, RT, LC, LD, RC, LM, RI, 24, 25, 57, 58, 78, 79, 27, 59, 91. Modifiers 22, 76 and 77 are not Medicaid PTP NCCI approved modifiers. If these modifiers are used, they will not bypass the Medicaid PTP NCCI edits.

Reconsideration

Providers that disagree with the action taken by a ClaimCheck/NCCI edit may request a reconsideration of the process via email (ClaimCheck@dmas.virginia.gov) or by submitting a request to the following mailing address:

Payment Processing Unit, Claim Check

Division of Program Operations

Department of Medical Assistance Services

600 East Broad Street, Suite 1300

Richmond, Virginia 23219

There is a 30-day time limit from the date of the denial letter or the date of the remittance advice containing the denial for requesting reconsideration. A review of additional documentation may sustain the original determination or result in an approval or denial of additional day(s). Requests received without additional documentation or after the 30-day limit will not be considered.

COST-BASED REIMBURSEMENT AND BILLING INSTRUCTIONS FOR LOCAL EDUCATION AGENCIES

The Individuals with Disabilities Education Act (IDEA) requires local education agencies (LEAs) to provide students with disabilities a free and appropriate public education, including special education and related services according to each student's Individualized Education Program (IEP). While LEAs are financially responsible for educational services, in the case of a Medicaid or CHIP-enrolled student, state agencies that administer Medicaid and CHIP programs may reimburse part of the allowable costs of providing the services identified in the student's IEP if they are covered under the state's plan for medical assistance and determined to be medically necessary by a qualified professional. (Virginia's CHIP program is known as the Family Access to Medical Insurance Security or FAMIS program.)

LEA providers submit claims based on the estimated costs for services furnished. DMAS makes interim payments to the LEAs based on these claims. Final payment is based on each local education agency or school division's costs reported and settled on an annual cost report. Personnel costs are determined by multiplying payroll costs of qualified practitioners times the percent of time qualified practitioners spend on medical services (determined by a statewide time study) times the percentage of IEP Special Education students that are Medicaid or FAMIS eligible. Non-personnel costs and indirect costs are also included.

LEAs must submit interim claims to receive final payment through the cost based reimbursement process. All interim payments are subject to recovery if a provider fails to file a cost report for services.

Local education agencies may contact DMAS Provider Reimbursement at 804-692-0816 for assistance with cost reporting.

Additional requirements for interim claiming:

- With the exception of personal care and specialized transportation services, and medical evaluation services performed by a physician, nurse practitioner or physician's assistant, a National Provider Identifier (NPI) of a DMAS-enrolled ordering, referring and prescribing (ORP) provider must be included on all service claims as a referring provider for school-based services. This includes claims for the telehealth originating site facility fee (Q3014).
- The following providers, if enrolled with DMAS as an ORP provider type, may refer students for covered school-based services authorized via the student's IEP: physicians, nurse practitioners, physician's assistants; and PT, OT, SLP, audiology and mental health service providers employed by or contracted with the school division to provide special education and related services.
- NPIs of any of the above listed qualified provider types may be used to satisfy the ORP NPI requirement for any covered school-based service that is included in a student's IEP.
- An exception to the above is nursing services. Claims for nursing services must include the NPI of an ordering physician, nurse practitioner or physician's assistant.

Service Authorization and Medical Necessity for Local Education Agencies

The Virginia State Plan for Medical Assistance, approved by the Centers for Medicare and Medicaid Services (CMS), designates the IEP as the certifying document for medical necessity for services provided by the LEA. The covered services are described in Chapter IV of this manual, and the provider qualifications for providing those services is described in Chapter II of this manual.

CLIA Certification (LEA)

Any laboratory claims submitted by local education agencies will be denied if no CLIA certificate and identification number is on file with DMAS. This requirement implements the federal Clinical Laboratory Improvement Amendment of 1988. To obtain a CLIA certificate and number or to obtain information about CLIA, call or write the Virginia Department of Health (VDH) at:

VDH Office of Health Facility Regulation

3600 Centre, Suite 216

3600 W. Broad Street

Richmond, Virginia 23230

804-367-2104

DMAS will deny claims for services outside of the CLIA certificate type, edit reason 480 (provider not CLIA certified to perform procedure).

Billing Instructions for the use of the Direct Data Entry / Professional (CMS-1500) Claims

Providers are encouraged to monitor all DMAS memorandums as well as the DMAS website(s) for additional directions.

To bill for professional services, the Direct Data Entry (DDE) for professionals (CMS-1500) invoice must be used unless an exception has been granted to continue the use of the Health Insurance Claim Form, CMS-1500 (02-12). To access the Claims DDE, please visit https://www.virginiamedicaid.dmas.virginia.gov, under Provider Resources, select Claims Direct Data Entry (DDE). This section of the website lists the Claims DDE User Guide, the Claims DDE FAQ and the Claims DDE Tutorial.

INSTRUCTIONS FOR THE USE OF THE CMS-1500 (02-12)

Starting April 1, 2014, the Direct Data Entry (DDE) CMS-1500 claim form on the Virginia Medicaid Web Portal will be updated to accommodate the changes to locators 21 and 24E on 4/1/2014. Please note that providers are encouraged to use DDE for submission of claims that cannot be submitted electronically to DMAS. Registration through the Virginia Medicaid Web Portal is required to access and use DDE. The DDE User Guide, tutorial and FAQ's can be accessed from our web portal at: www.virginiamedicaid.dmas.virginia.gov. To access the DDE system, select the Provider Resources tab and then select Claims Direct Data Entry (DDE). Providers have the ability to create a new initial claim, as well as an adjustment or a void through the DDE process. The status of the claim(s) submitted can be checked the next business day if claims were submitted by 5pm. DDE is provided at no cost to the provider. Paper claim submissions should only be submitted when requested specifically by DMAS.

To bill for services, the Health Insurance Claim Form, CMS-1500 (02-12), invoice form must be used for paper claims **received on or after April 1, 2014**. The following instructions have numbered items corresponding to fields on the CMS-1500 (02-12). The purpose of the CMS-1500 (02-12) is to provide a form for participating providers to request reimbursement

for covered services rendered to Virginia Medicaid members.

SPECIAL NOTE: The provider number in locator 24J must be the same in locator 33 unless the Group/Billing Provider relationship has been established and approved by DMAS for use.

Locator		Instructions
1	**REQUIRED**	**Enter an "X" in the MEDICAID box for the Medicaid Program.**
1a	**REQUIRED**	**Insured's I.D. Number -** Enter the 12-digit Virginia Medicaid Identification number for the member receiving the service.
2	**REQUIRED**	**Patient's Name -** Enter the name of the member receiving the service.
3	NOT REQUIRED	Patient's Birth Date
4	NOT REQUIRED	Insured's Name
5	NOT REQUIRED	Patient's Address
6	NOT REQUIRED	Patient Relationship to Insured
7	NOT REQUIRED	Insured's Address
8	NOT REQUIRED	Reserved for NUCC Use
9	NOT REQUIRED	Other Insured's Name
9a	NOT REQUIRED	Other Insured's Policy or Group Number
9b	NOT REQUIRED	Reserved for NUCC Use
9c	NOT REQUIRED	Reserved for NUCC Use
9d	NOT REQUIRED	Insurance Plan Name or Program Name

Locator		Instructions
10	**REQUIRED**	**Is Patient's Condition Related To: -** Enter an "X" in the appropriate box. a. Employment? b. Auto accident c. Other Accident? (This includes schools, stores, assaults, etc.) NOTE: The state postal code should be entered if known.
10d	Conditional	**Claim Codes (Designated by NUCC)** Enter "ATTACHMENT" if documents are attached to the claim form.
11	NOT REQUIRED	Insured's Policy Number or FECA Number
11a	NOT REQUIRED	Insured's Date of Birth
11b	NOT REQUIRED	Other Claim ID
11c	NOT REQUIRED	Insurance Plan or Program Name
11d	NOT REQUIRED	Is There Another Health Benefit Plan?
12	NOT REQUIRED	Patient's or Authorized Person's Signature
13	NOT REQUIRED	Insured's or Authorized Person's Signature
14	**REQUIRED If Applicable**	**Date of Current Illness, Injury, or Pregnancy** **Enter date MM DD YY format** **Enter Qualifier 431 – Onset of Current Symptoms or Illness**
15	NOT REQUIRED	Other Date
16	NOT REQUIRED	Dates Patient Unable to Work in Current Occupation
17	**REQUIRED If applicable**	**Name of Referring Physician or Other Source** – Enter the name of the referring physician.
17a shaded red	**REQUIRED If applicable**	**I.D. Number of Referring Physician** - The '1D' qualifier is required when the Atypical Provider Identifier (API) is entered. The qualifier 'ZZ' may be entered if the provider taxonomy code is needed to adjudicate the claim. This item is not applicable to school-based services.
17b	**REQUIRED If applicable**	**I.D. Number of Referring Physician** - Enter the National Provider Identifier of the referring (ORP) physician/provider.
18	NOT REQUIRED	Hospitalization Dates Related to Current Services

Locator		Instructions
19	**REQUIRED** **If applicable**	**Additional Claim Information** Enter the CLIA #.
20	NOT REQUIRED	Outside Lab
21 **A-L**	**REQUIRED**	**Diagnosis or Nature of Illness or Injury** - Enter the appropriate ICD diagnosis code, which describes the nature of the illness or injury for which the service was rendered in locator 24E. Note: Line 'A' field should be the Primary/Admitting diagnosis followed by the next highest level of specificity in lines B-L. **Note: ICD Ind. Not required at this time.** **9= ICD-9-CM** **0=ICD-10-CM**
22	**REQUIRED** **If applicable**	**Resubmission Code – Original Reference Number**. Required for adjustment and void. See the instructions for Adjustment and Void Invoices.
23	**REQUIRED** **If applicable**	**Prior Authorization (PA) Number** – Enter the PA number for approved services that require a service authorization.

NOTE: The locators 24A thru 24J have been divided into open areas and a shaded line area. **The shaded area is ONLY for supplemental information**. DMAS has given instructions for the supplemental information that is required when needed for DMAS claims processing. **ENTER REQUIRED INFORMATION ONLY.**

24A lines 1-6 open area	**REQUIRED**	**Dates of Service -** Enter the from and thru dates in a 2-digit format for the month, day and year (e.g., 01/01/14). DATES MUST BE WITHIN THE SAME MONTH

Locator		Instructions
24A lines 1-6 red shaded	**REQUIRED If applicable**	**DMAS requires the use of qualifier 'TPL'.** This qualifier is to be used whenever an actual payment is made by a third party payer. The 'TPL' qualifier is to be followed by the dollar/cents amount of the payment by the third party carriers. Example: Payment by other carrier is $27.08; red shaded area would be filled as **TPL27.08**. No spaces between qualifier and dollars. No $ symbol but the decimal between dollars and cents is required. **DMAS requires the use of the qualifier 'N4'.** This qualifier is to be used for the National Drug Code (NDC) whenever a HCPCS drug related code is submitted in 24D to DMAS. No spaces between the qualifier and the NDC number. **NOTE: DMAS is requiring the use of the Unit of Measurement Qualifiers following the NDC number for claims received on and after May 26, 2014. The unit of measurement qualifier code is followed by the metric decimal quantity** **Unit of Measurement Qualifier Codes:** **F2 – International Units** **GR – Gram** **ML – Milliliter** **UN – Unit** **Examples of NDC quantities for various dosage forms as follows:** **a. Tablets/Capsules – bill per UN** **b. Oral Liquids – bill per ML** **c. Reconstituted (or liquids) injections – bill per ML** **d. Non-reconstituted injections (I.E. vial of Rocephin powder) – bill as UN (1 vial = 1 unit)** **e. Creams, ointments, topical powders – bill per GR** **f. Inhalers – bill per GR**
24B open area	**REQUIRED**	**Place of Service -** Enter the 2-digit CMS code, which describes where the services were rendered.

Locator		Instructions
24C open area	**REQUIRED If applicable**	**Emergency Indicator -** Enter either 'Y' for YES or leave blank. **DMAS will not accept any other indicators for this locator.**
24D open area	**REQUIRED**	**Procedures, Services or Supplies – CPT/HCPCS – ter HCPCS Code, which des** Enter the CPT/HCPCS code that describes the procedure rendered or the service provided. **Modifier -** Enter the appropriate CPT/HCPCS modifiers if applicable.
24E open area	**REQUIRED**	**Diagnosis Code -** Enter the diagnosis code reference letter A-L (pointer) as shown in Locator 21 to relate the date of service and the procedure performed to the primary diagnosis. The primary diagnosis code reference letter for each service should be listed first. **NOTE: A maximum of 4 diagnosis code reference letter pointers should be entered.** Claims with values other than A-L in Locator 24-E or blank may be denied.
24F open area	**REQUIRED**	**Charges -** Enter your total usual and customary charges for the procedure/services.
24G open area	**REQUIRED**	**Days or Unit -** Enter the number of times the procedure, service, or item was provided during the service period.
24H open area	**REQUIRED If applicable**	**EPSDT or Family Planning -** Enter the appropriate indicator. Required only for EPSDT or family planning services. 1 - Early and Periodic, Screening, Diagnosis and Treatment Program Services 2 - Family Planning Service
24I open	**REQUIRED If applicable**	**NPI –** This is to identify that it is a NPI that is in locator 24J

Locator		Instructions
24 I red-shaded	**REQUIRED If applicable**	**ID QUALIFIER –T**he qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 24J open line. The qualifier '1D' is required for the API entered in locator 24J red shaded line.
24J open	**REQUIRED If applicable**	**Rendering provider ID# -** Enter the 10 digit NPI number for the provider that performed/rendered the care.
24J red-shaded	**REQUIRED If applicable**	**Rendering provider ID#** - School-based providers enter the school division NPI as the rendering provider here.
25	NOT REQUIRED	Federal Tax I.D. Number
26	**REQUIRED**	**Patient's Account Number** – Up to **FOURTEEN** alpha-numeric characters are acceptable.
27	NOT REQUIRED	Accept Assignment
28	**REQUIRED**	**Total Charge -** Enter the total charges for the services in 24F lines 1-6
29	**REQUIRED If applicable**	**Amount Paid – For personal care and waiver services only –**enter the patient pay amount that is due from the patient. **NOTE:** The patient pay amount is taken from services billed on 24A – line 1. If multiple services are provided on same date of service, then another form must be completed since only one line can be submitted if patient pay is to be considered in the processing of this service.
30	NOT REQUIRED	Reserved for NUCC Use
31	**REQUIRED**	**Signature of Physician or Supplier Including Degrees or Credentials -** The provider or agent must sign and date the invoice in this block.

Locator		Instructions
32	**REQUIRED If applicable**	**Service Facility Location Information –** Enter the name as first line, address as second line, city, state and 9 digit zip code as third line for the location where the services were rendered. **NOTE:** For physician with multiple office locations, the specific Zip code must reflect the office location where services given. Do NOT use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code.
32a open	**REQUIRED If applicable**	**NPI # -** Enter the 10 digit NPI number of the service location.
32b red shaded	**REQUIRED If applicable**	**Other ID#:** - The qualifier '1D' is required for the API entered in this locator. The qualifier of 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 32a open line.
33	**REQUIRED**	**Billing Provider Info and PH # -** Enter the billing name as first line, address as second line, city, state and 9-digit zip code as third line. This locator is to identify the provider that is requesting to be paid**.** **NOTE: Do NOT** use commas, periods or other punctuations in the address. Enter space between city and state. Include the hyphen for the 9 digit zip code. The phone number is to be entered in the area to the right of the field title. Do not use hyphen or space as separator within the telephone number.
33a open	**REQUIRED**	**NPI –** Enter the 10 digit NPI number of the billing provider.
33b red shaded	**REQUIRED If applicable**	**Other Billing ID -** The qualifier '1D' is required for the API entered in this locator. The qualifier 'ZZ' can be entered to identify the provider taxonomy code if the NPI is entered in locator 33a open line. **NOTE: DO NOT** use commas, periods, space, hyphens or other punctuations between the qualifier and the number.

Instructions for the Completion of the Health Insurance Claim Form, CMS-1500 (02-12), as an Adjustment Invoice

The Adjustment Invoice is used to change information on an approved claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the adjustment invoice.

1023	Primary Carrier has made additional payment
1024	Primary Carrier has denied payment
1025	Accommodation charge correction
1026	Patient payment amount changed
1027	Correcting service periods
1028	Correcting procedure/service code
1029	Correcting diagnosis code
1030	Correcting charges
1031	Correcting units/visits/studies/procedures
1032	IC reconsideration of allowance, documented
1033	Correcting admitting, referring, prescribing, provider identification number
1053	Adjustment reason is in the Misc. Category

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be adjusted. Only one claim can be adjusted on each CMS-1500 (02-12) submitted as an Adjustment Invoice. (Each line under Locator 24 is one claim)

NOTE: ICNs can only be adjusted through the Virginia MMIS. LEAs must complete needed adjustments within one year from the date the claim was paid in order to ensure the adjustment is applied to the correct cost-settlement year.

After three years, ICNs are purged from the Virginia MMIS and can no longer be adjusted through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services

Attn: Fiscal & Procurement Division, Cashier

600 East Broad St. Suite 1300

Richmond, VA 23219

INSTRUCTIONS FOR THE COMPLETION OF THE HEALTH INSURANCE CLAIM FORM CMS 1500 (02-12), AS A VOID INVOICE

The Void Invoice is used to void a paid claim. Follow the instructions for the completion of the Health Insurance Claim Form, CMS-1500 (02-12), except for the locator indicated below.

Locator 22 **Medicaid Resubmission**

Code - Enter the 4-digit code identifying the reason for the submission of the void invoice.

1042	Original claim has multiple incorrect items
1044	Wrong provider identification number
1045	Wrong enrollee eligibility number
1046	Primary carrier has paid DMAS maximum allowance
1047	Duplicate payment was made
1048	Primary carrier has paid full charge
1051	Enrollee not my patient

1052	Miscellaneous
1060	Other insurance is available

Original Reference Number/ICN - Enter the claim reference number/ICN of the paid claim. This number may be obtained from the remittance voucher and is required to identify the claim to be voided. Only one claim can be voided on each CMS-1500 (02-12) submitted as a Void Invoice. (Each line under Locator 24 is one claim).

NOTE: ICNs can only be voided through the Virginia MMIS up to three years from the **date the claim was paid**. After three years, ICNs are purged from the Virginia MMIS and can no longer be voided through the Virginia MMIS. If an ICN is purged from the Virginia MMIS, the provider must send a refund check made payable to DMAS and include the following information:

- A cover letter on the provider's letterhead, which includes the current address, contact name and phone number.
- An explanation about the refund.
- A copy of the remittance page(s) as it relates to the refund check amount.

Mail all information to:

Department of Medical Assistance Services

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Group Practice Billing Functionality

Providers defined in this manual are not eligible to submit claims as a Group Practice with the Virginia Medicaid Program. Group Practice claim submissions are reserved for independently enrolled fee-for-service healthcare practitioners (physicians, podiatrists, psychologists, etc.) that share the same Federal Employer Identification Number. Facility-

based organizations (NPI Type 2) and providers assigned an Atypical Provider Identifier (API) may not utilize group billing functionality.

Medicare Crossover: If Medicare requires you to submit claims identifying an individual Rendering Provider, DMAS will use the Billing Provider NPI to adjudicate the Medicare Crossover Claim. You will not enroll your organization as a Group Practice with Virginia Medicaid.

For more information on Group Practice enrollment and claim submissions using the CMS-1500 (02-12), please refer to the appropriate practitioner Provider Manual found at www.dmas.virginia.gov

Negative Balance Information

Negative balances occur when one or more of the following situations have occurred:

- Provider submitted adjustment/void request
- DMAS completed adjustment/void
- Audits
- Cost settlements
- Repayment of advance payments made to the provider by DMAS

In the remittance process the amount of the negative balance may be either off set by the total of the approved claims for payment leaving a reduced payment amount or may result in a negative balance to be carried forward. The remittance will show the amount as, “less the negative balance” and it may also show “the negative balance to be carried forward”.

The negative balance will appear on subsequent remittances until it is satisfied. An example is if the claims processed during the week resulted in approved allowances of $1000.00 and the provider has a negative balance of $2000.00 a check will not be issued, and the remaining $1000.00 outstanding to DMAS will carry forward to the next remittance.

INVOICE PROCESSING (LEA)

The DMAS invoice processing system utilizes a sophisticated electronic system to process claims. Upon receipt, a claim is scanned or directly keyed, assigned a claim reference number, and entered into the MMIS system. The claim is then placed in one of the following categories:

Remittance Voucher (Payment Voucher) - DMAS sends a Remittance Voucher with each payment. This voucher lists the approved, pended, denied, adjusted, or voided claims and should be kept in the provider's permanent files. The first page of the voucher contains a space for special messages from DMAS. The sections of the Remittance Voucher are:

Approved - These are claims which have been approved and for which the provider is being reimbursed;

Pended - These claims are being reviewed. The final adjudication of this claim will be a later Remittance Voucher;

Denied - These claims are denied and are not reimbursable by DMAS as submitted (e.g., the submission of a duplicate claim of a previously-submitted claim);

Debit - This section lists any formerly paid claims which have been adjusted, thereby creating a positive balance;

Credit - This section lists any formerly paid claims which have been either adjusted or voided and have created a negative balance; and

Provider Number - The NPI number assigned to the individual

provider. Include this number in all correspondence with DMAS.

No Response - If one of the above responses has not been received within 30 days, the provider should assume non-delivery and rebill using a new invoice form.

The provider's failure to follow up on these situations does not warrant individual or additional consideration for late billing.

Local Education Agency Service Codes

LEA providers submit claims based on the estimated costs for services furnished. DMAS makes interim payments on claims. Final payment will be based on each local education agency's costs reported and settled on an annual cost report. The LEA may contact DMAS Provider Reimbursement at 804-692-0816 for assistance with cost reports. Please visit the Department of Education website at www.doe.virginia.gov or the Department of Medical Assistance Services website at www.dmas.virginia.gov for more information. Note: Final reimbursement will depend upon the settlement of the cost report.

The codes listed below have a detailed description in the Current Procedural Terminology (CPT) manual or the Healthcare Common Procedure Coding System (HCPCS) manual. Please consult these manuals for guidance on the use of the codes.

Physical, Occupational and Speech-Language Therapies

CODE	SERVICE DESCRIPTION	UNIT
97163	Physical Therapy Assessment	Per assessment
97110	Physical Therapy Individual Visit	Per visit
97150	Physical Therapy Group Session	Per individual/Per session
97167	Occupational Therapy Assessment	Per assessment
97530	Occupational Therapy Individual Visit	Per visit
S9129	Occupational Therapy Group Session	Per individual/Per session
92521[1]	Evaluation of speech fluency (e.g., stuttering, cluttering)_	Per assessment
92522[1]	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	Per assessment

92523[1,2]	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	Per assessment
92524[1]	Behavioral and qualitative analysis of voice and resonance	Per assessment
92507[1]	Speech Therapy Individual Visit	Per visit
92508[1]	Speech Therapy Group Session	Per individual/Per session

[2]The modifier "52" must be used with code 92523 if a patient is evaluated only for language, with no documentation of an assessment of speech (formal or informal). The "52" modifier is used when the services provided are reduced in comparison with the full description of the service.

Nursing

CODE	SERVICE DESCRIPTION	UNIT
T1002	Nursing Services	15 minutes or less

Service Limits for Nursing

Nursing services are limited to 6.5 hours per day or 26 units per day.

To calculate monthly units billed, add the total monthly time spent providing nursing services and divide by 15 (a unit) to get the total number of units to be billed for that month. If the total number of units billed ends up with a fraction of a unit, round to the nearest unit.

Psychiatry, Psychology, and Mental Health

CODE*	SERVICE DESCRIPTION (One unit is per visit unless otherwise noted.)	UNIT
90791	Psychiatric diagnostic interview examination	Per exam

90791 and 90785	Interactive psychiatric diagnostic interview examination using play equipment, physical devices, language interpreter, or other mechanisms of communication	Per exam
90832	Individual psychotherapy, insight oriented behavior modifying and/or supportive in an office or outpatient facility	Approximately 30 minutes face-to-face with patient
90834	Individual psychotherapy, insight oriented, behavior modifying and/or supportive in an office or outpatient facility	Approximately 45 minutes face-to-face with patient
90837	Individual psychotherapy, insight oriented, behavior modifying and/or supportive in an office or outpatient facility	Approximately 60 minutes face-to-face with patient
90832 and 90785	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility	Approximately 30 minutes face-to-face with patient
90834 and 90785	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility	Approximately 45minutes face-to-face with patient
90837 and 90785	Individual psychotherapy, interactive, using play equipment, physical devices, language interpreter, or other mechanisms of non-verbal communication in an office or outpatient facility	Approximately 60 minutes face-to-face with patient
90846	Family Psychotherapy (without the patient present)	Per session
90847	Family Psychotherapy (conjoint Psychotherapy with patient present)	Per session
90853	Group Psychotherapy (Other than of a Multiple Family Group)	Per session
90853 and 90785	Interactive Group Psychotherapy	Per session
96110	Developmental screening, scoring and documentation	Per instrument
96112	Developmental test administration, interpretation and report, first hour only	Per 1st hour
96113	each additional 30 min	Per additional 30 min
96127	Brief emotional/behavioral assessment, scoring and documentation	Per instrument

CODE*	SERVICE DESCRIPTION (One unit is per visit unless otherwise noted.)	UNIT
96116	NEUROBEHAVIORAL STATUS EXAM, BOTH FACE-TO-FACE TIME WITH THE PATIENT AND TIME INTERPRETING TEST RESULTS AND PREPARING THE REPORT, FIRST HOUR ONLY	PER HOUR
96121	each additional hour	Per hour
96130	Psychological testing evaluation services, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregivers when performed, first hour only	Per hour
96131	each additional hour	Per hour
96136[f]	Psychological or neuropsychological test admin & scoring by physician or other QHP, 2 or more tests, any method, first 30 minutes only	Per 30 min
96137	each additional 30 min	Per 30 min
96138	Psychological or neuropsychological test admin & scoring by technician, 2 or more tests, any method, first 30 minutes only	Per 30 min
96139	each additional 30 minutes	Per 30 min
96146	Psychological or neuropsychological test admin, with single automated, standardized instrument via electronic platform, with automated result only	Per single test administration**
96132	Neuropsychological testing evaluation services by physician or other QHP, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family members(s) or caregiver(s) when performed, first hour only	Per hour
96133	each additional hour	Per hour

* Local education agencies must use a modifier below when billing for these services to identify the provider.

U6	Psychiatrist
AH	Licensed Clinical Psychologist

AJ	Licensed Clinical Social Workers Licensed Professional Counselors Licensed School Psychologist Licensed School Psychologist-Limited	Psychiatric Clinical Nurse Specialist Licensed Marriage and Family Therapists School Social Worker

** Only one unit of this code may be billed per psychological testing evaluation episode, regardless of number of automated tests administered.

[f] 96136 and 96138 may not both be billed for same student in the same day.

Audiology

CODE	SERVICE DESCRIPTION
92553	Pure tone audiometry (threshold); Air and bone
92555	Speech audiometry threshold
92556	Speech audiometry threshold with speech recognition
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)
92559	Audiometric testing of groups
92560	Bekesy audiometry; screening
92561	Bekesy audiometry; diagnostic
92562	Loudness balance test, alternate binaural or monaural
92563	Tone decay test
92564	Short increment sensitivity index (SISI)
92565	Stenger test, pure tone
92567	Tympanometry (impedance testing)
92568	Acoustic reflex testing; threshold
92569	Acoustic reflex testing; decay
92571	Filtered speech test
92572	Staggered spondaic word test
92575	Sensorineural acuity level test
92576	Synthetic sentence identification test
92577	Stenger test, speech
92579	Visual reinforcement audiometry (VRA)
92582	Conditioning play audiometry
92583	Select picture audiometry
92584	Electrocochleography
92585	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; comprehensive

92586	Auditory evoked potentials for evoked response audiometry and/or testing of the central nervous system; limited
92587	Evoked otoacoustic emissions; limited (single stimulus level, either transient or distortion products)
92588	Evoked otoacoustic emissions; comprehensive or diagnostic evaluation (comparison of transient and/or distortion product otoacoustic emissions at multiple levels and frequencies)
92589	Central Auditory Function Test(s)
92592	Hearing aid check; monaural
92593	Hearing aid check; binaural
92594	Electroacoustic Evaluation for hearing aid; monaural
92595	Electroacoustic Evaluation for hearing aid; binaural
92596	Ear Protector Attenuation Measurement
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with subsequent programming
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming
92604	Diagnostic analysis of cochlear implant, age 7 years or older; with subsequent programming
92620	Evaluation of central auditory function with report; initial 60 minutes
92621	Evaluation of central auditory function with report; each additional 15 minutes
92625	Assessment of tinnitus (including pitch, loudness matching, and masking)
92626	Evaluation of auditory rehabilitation status; first hour
92627	Evaluation of auditory rehabilitation status; each additional 15 minutes
92630	Auditory rehabilitation; prelingual hearing loss
92633	Auditory rehabilitation; postlingual hearing loss

Medical Evaluations

CODE	SERVICE DESCRIPTION	UNIT
T1024	Medical Evaluation by MD, NP or PA as part of IEP process	Per encounter

Specialized Transportation

CODE	SERVICE DESCRIPTION	UNIT

T2003	Specialized Transportation (non-emergency)	Per one way trip

Personal Care Assistance

CODE	SERVICE DESCRIPTION	UNIT
T2027	Personal Care Services	15 minutes or less

Service Limits for Personal Care Assistance Services

Personal care assistance services are limited to 8.5 hours per day or 34 units per day.

To calculate monthly units billed, add the time for providing personal care assistant services and divide by 15 (a unit) to get the total number of units to be billed. If the total number of units billed ends up with a fraction of a unit, round to the nearest unit.

For example, the total time to assist a student with feeding during lunch is 550 minutes for a month. Divide the total time by 15 to get the billable minutes (550 / 15 = 36.66). The total units billed would be 37 (round to the nearest unit). If the total time so assist the student with feeding during lunch is 500 minutes for a month, the total time would be divided by 15 to get the billable minutes (500 / 15 = 33.33) and rounded to nearest unit (33.33 = 33 units).

TELEMEDICINE BILLING INFORMATION

Service providers must include the modifier GT on claims for services delivered via telemedicine.

Place of Service (POS), the two-digit code placed on claims used to indicate the setting where the service occurred, must reflect the location in which a telehealth service would have normally been provided, had interactions occurred in person. The school setting code is 03. (Providers should not use POS 02 on telehealth claims, even though this POS is referred to as “telehealth” for other payers.

The services of a school employee supervising the student at the originating school site (the site where the student is located during the telehealth service), must be billed using

procedure code, Q3014.

EPSDT

Local education agency health centers will get 100% rate reimbursement for screening services and related tests for students with "fee-for-service" coverage. DMAS will not reimburse local education agencies directly for EPSDT screening services and related tests for students enrolled in a DMAS Managed Care Organization (MCO). The provider must contact the individual MCO regarding contract negotiations for providing EPSDT services for children enrolled in an MCO. For specific and up-to-date information about EPSDT or specific vaccination coverage, please refer to the EPSDT Supplemental Provider Manual located on the DMAS website atwww.virginiamedicaid.dmas.virginia.gov.

CODE	SERVICE DESCRIPTION	UNIT
EPSDT Health, Vision and Hearing Screenings		
92551	Screening test, pure tone , air only	Per test
92552	Pure tone audiometry (threshold); air only	Per test
99173	Screening test of visual acuity, quantitative, bilateral	Per test
99381	Initial comprehensive preventive medicine, new patient infant (age under 1 year)	Per exam
99382	Initial comprehensive preventive medicine, new patient infant; early childhood (age 1 through 4 years)	Per exam
99383	Initial comprehensive preventive medicine, new patient infant; late childhood (age 5 through 11 years)	Per exam
99384	Initial comprehensive preventive medicine, new patient infant; adolescent (age 12 through 17 years)	Per exam
99385	Initial comprehensive preventive medicine, new patient infant; 18 – 39 years	Per exam
99391	Periodic comprehensive preventive medicine; infant (age under 1 year)	Per exam
99392	Periodic comprehensive preventive medicine; early childhood (age 1 through 4 years)	Per exam
99393	Periodic comprehensive preventive medicine; late childhood (age 5 through 11 years)	Per exam

99394	Periodic comprehensive preventive medicine; adolescent (age 12 through 17 years)	Per exam
99395	Periodic comprehensive preventive medicine; 18 – 39 years	Per exam

EPSDT Inter-periodic Screenings		
New Patient		
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 15-29 minutes	Per visit
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 30-44 minutes	Per visit
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. 45-59 minutes	Per visit

Established Patient		
99211	Office or other outpatient visit for the evaluation and management of an established patient that may not require the presence of a physician. Usually the presenting problem(s) are minimal	Per visit
99212	Office or other outpatient visit for the evaluation and management of an established patient.10-19 minutes	Per visit

99213	Office or other outpatient visit for the evaluation and management of an established patient. 20-29 minutes	Per visit
99214	Office or other outpatient visit for the evaluation and management of an established patient. 30-39 minutes	Per visit

Utilization Review and Control (LEA)

INTRODUCTION

Under the provisions of federal regulations, Medical Assistance Programs must provide for continuing review and evaluation of care and services paid by Medicaid and the Children's Health Insurance Program (CHIP), including review of utilization of the services by providers and by recipients. Federal regulations at 42 CFR §§ 455–456 and 42 CFR §§ 457.490 set forth requirements for detection and investigation of fraud and abuse to maintain program integrity, and require implementation of a statewide program of utilization control to ensure high quality care as well as the appropriate provision of services. This chapter provides information on documentation requirements (referred to in this chapter as Medicaid documentation requirements) and quality management reviews handled by the Department of Medical Assistance Services (DMAS).

FINANCIAL REVIEW AND VERIFICATION (LEA)

The purpose of financial review and verification of services is to ensure that the provider bills only for those services that have been provided in accordance with DMAS policy and that are covered under the Virginia Medical Assistance programs and services. Any paid provider claim that cannot be verified at the time of review cannot be considered a valid claim for services provided, and is subject to retraction.

GENERAL DOCUMENTATION REQUIREMENTS (LEA)

Local Education Agency (LEA) providers, and their associated service rendering providers must follow the general documentation requirements for all providers as outlined in the Physician/Practitioner Provider Manual located on the Virginia Medicaid Portal, as well as additional documentation requirements for specific services outlined in this chapter. Documentation must also be in accordance with the requirements of the applicable licensing board and applicable Virginia statutes and regulations.

Records of services must be retained for not less than six years after the last date of

service. Documentation must be complete, accurate, readily accessible and systematically organized to facilitate retrieval and compilation of information upon request of DMAS. Service documentation to support billing must clearly identify the recipient of services using the student's full name, and Medicaid or FAMIS ID number. The provider must maintain adequate facilities and equipment, conveniently located, to provide efficient processing of the clinical records (reviewing, indexing, filing, and prompt retrieval). Refer to 42 CFR 485.721 for additional requirements.

The following types of service documentation must be maintained and made accessible at the request of DMAS:

Individualized Education Program (IEP) Documentation

The IEP plan is used to document those services that are medically necessary, require the skill level of or supervision by a DMAS-qualified provider, and that the treatment prescribed is in accordance with standards of medical practice.

Service-Specific Evaluations

DMAS covers evaluations performed by a DMAS-qualified provider, acting within the scope of his or her license. This includes Medical Evaluations performed by a physician, nurse practitioner or physician assistant, and evaluations performed by specific covered service-providing disciplines (Physical Therapy (PT), Occupational Therapy (OT), Speech and Language Pathology (SLP), Audiology, or Psychiatry, Psychology and Mental Health. In order to bill for evaluations, the evaluation (listed as a service) or the service type providing the evaluation (i.e., PT, OT, SLP, Audiology, or Psychiatry, Psychology and Mental Health) must be included or referenced in the student's IEP.

Plans of Care (POC)

A plan of care (POC) must be documented for on-going PT, OT, SLP, Audiology, Nursing and Personal Care services referenced in the IEP. Each POC must include:

- The medical diagnosis or identifying issue to be addressed by the service;
- Type and frequency of service required to address the issue;
- Measurable long term goals;
- Interventions, treatments or modalities associated with each goal;
- Goals must relate to the services outlined in the IEP;
- Date of POC implementation; and
- Signature, title and date (month/day/year) of the DMAS qualified provider as confirmation that they developed the POC.

Student Progress or Service Logs

Documentation of on-going services provided and student progress (e.g., progress notes, service logs) must be maintained as required for the provider type and must:

- Clearly identify the provider/therapist rendering the service;
- Include progress/response to treatment being made; and any change in the identifying issue or treatment; and
- Be completed as soon as possible.

For services rendered by providers under supervision, the progress or service logs must also contain:

- Supervisor confirmation that services rendered by persons under their direction were carried out according to the documented plan of care. Confirmation must include the supervisor's signature; and
- Supervisor signature confirmation of a supervisory visit at least every 90 days for purposes of ensuring that services are being carried out according to the plan of care.

Signatures

All documentation requiring a provider signature must use a signature format including the first initial, last name and title of the provider, and dated (month/day/ye).

Electronic Signatures

Providers must follow DMAS guidelines set forth regarding electronic signatures. DMAS requirements for electronic signatures are listed in the DMAS Physician/Practitioner Manual, Chapter VI.

SERVICE-SPECIFIC DOCUMENTATION REQUIREMENTS

Medical Evaluations

In addition to the general documentation requirements stated previously in this chapter, documentation of medical evaluations must also include the following:

- Positive and negative examination findings;

- Diagnostic tests ordered and the results of the tests;
- Diagnoses;
- An indication of whether further treatment is needed; and
- Referral sources, including the name of the referring physician, nurse practitioner or physician assistant.

Physical Therapy, Occupational Therapy, Speech-Language Pathology and Audiological Services

In addition to the general documentation requirements stated previously in this chapter, the record must also include the following:

- Documentation of service-specific evaluation results that include:
  - Reason for the evaluation;
  - Medical/treating diagnoses;
  - Current findings;
  - Current functional status (strengths and deficits); and
  - Summary of previous treatment and results.
- A POC that includes:
  - The specific medical diagnosis or identifying issue to be addressed by the service;
  - Type and frequency of service required to address the issue;
  - Long-term goals that:
    - Relate to the services outlined in the IEP;
    - Are expressed in terms of desired, measurable functional outcomes;
    - Specify interventions, treatments, modalities or methods to be used to achieve the goal;
    - Include the date of POC implementation; and
    - Include a time frame for achieving the goal that is no longer than one year from the implementation date of the POC.
  - A discharge goal or goals.
  - Signature, title and date (month/day/year) of the DMAS qualified provider as confirmation that they developed the POC.

A POC is valid for up to 12 months from date of implementation, however, the POC must be revised when there are significant changes in the student's condition and/or functional status that necessitate changes to their treatment, goals, or frequency or duration of services. Such changes may be documented with a new POC or as an addendum to an existing POC.

When POC changes are due solely to the child's participation in summer session (i.e., extended school year) those changes may be reflected in an addendum to the student's POC. A new POC is not required. In these cases, the provider may revert back to the primary POC at the end of summer session, when the new school year begins.

- A discharge summary must be completed when a service is discontinued. The discharge summary must include:
  - A summary of the student's progress relative to treatment goals;
  - The reason for discharge;
  - The student's functional status at discharge compared to admission status;
  - The student's status relative to established long-term goals met or not met;
  - The recommendations for any follow-up care; and
  - The full signature, title and date (month/day/year) by the qualified provider completing the discharge summary.

Note, a discharge summary must also be written if the service continues, but no longer meets DMAS requirements for billing (i.e., qualified provider determines that services are not required, but IEP team determines that services will continue).

A discharge summary is not required if:

  - The student and their IEP are transferring to another school within the division, and the services are to continue; or
  - Services are temporarily paused, regardless of reason, but the IEP remains in place and the qualified provider intends to resume the current plan of care.

Nursing

In addition to the general documentation requirements stated previously in this chapter, nursing documentation must include the following:

- A written order from a DMAS-enrolled physician, nurse practitioner or

physician assistant for skilled nursing services and services supervised by a nurse;

- A POC that includes:
  - All services resulting from physician, physician assistant and/or nurse practitioner written order(s). Multiple written orders from multiple qualified providers may be documented together in a single plan of care;
  - The specific medical condition or conditions, including applicable ICD diagnosis code(s) to be addressed by nursing services;
  - Goals and objectives for each nursing service included;
  - Medication, treatment and/or procedures required by the nurse for each goal addressed;
  - Time tables including dose (as applicable for medications) and frequency of service; and
  - Signature of the RN completing the POC.

- A Nursing Log that includes:
  - Student name and date of birth;
  - Student's Medicaid or FAMIS 12-digit ID number;
  - Current diagnosis;
  - Date (month/day/year), time of day, and amount of time (total number of minutes) of the nursing service entered by the responsible licensed nurse;
  - Actual nursing procedure rendered;
  - Student's response to treatment;
    - N = Normal
    - V = Variance from normal or standard. Note: If the student's response is a variance from normal or standard, the responsible licensed nurse must document a written explanation in the comment section of the Student Log.
  - Actions related to nursing services, including notifying parents, calling the physician or notifying emergency medical services, as applicable;
  - Any prescribed drugs which are part of the POC, including dosage, route of administration and frequency;
  - Any changes from the physician, physician assistant or nurse practitioner written order;
  - Identification of the nurse rendering the service; and
  - Signature of a licensed RN as confirmation that services

rendered by themselves or persons under their direction were carried out according to the Plan of Care.

Psychiatry, Psychology, and Mental Health

In addition to the documentation requirements for all LEA providers outlined in the beginning of this chapter, documentation supporting psychiatry, psychology and mental health services must also include the following, regardless of the type of psychiatry, psychology or mental health service provided or type of provider providing the service:

- Educational history, medical history, family history and previous psychological treatment to include:
  - The onset of the diagnosis and functional limitations;
  - Situational factors that may impact treatment (e.g., foster care, incarcerated parent);
  - Previous treatment and outcomes;
  - Medications, current and history of;
  - Medical history, if relative to current treatment;
  - Treatment received through other programs (e.g., Department for Aging and Rehabilitative Services, Therapeutic Day Treatment, Special Education, Community Services Board, or other behavioral health providers (intensive in-home and other therapy services, medications, etc.).

Documentation to support on-going counseling services must also include:

- A mental status examination
- A plan for treatment that includes:
  - Individual-specific goals related to symptoms and behaviors;
  - Treatment modalities to be used;
  - Estimated length that treatment will be needed;
  - Frequency of the treatments/duration of the treatment; and
  - Documentation of family/caregiver participation in the plan for treatment (if applicable).
- Diagnostic impressions documented with in the previous 12 months.

Documentation to support psychological testing evaluation services must include:

- Clear referral question and presenting concern(s);
- Source(s) of information used in completing the evaluation;
- Tests administered;
- Interpretation of test data and other clinical information;
- Diagnostic impressions; and
- Recommendations

Documentation for each billed counseling session must include:

- Length of the session;
- Level of participation in treatment;
- Type of session (e.g., group, individual);
- How the activities of the session relate to the student-specific goals;
- Progress or lack thereof toward the goals;
- Plan for the next session; and
- Signature of the provider

Personal Care Assistance

In addition to the general documentation requirements for all LEA providers outlined in the beginning of this chapter, documentation for personal care services must also include the following:

- A POC that includes:
    - The specific medical diagnosis or identifying issue to be addressed by the personal care service.
    - Type of intervention, treatment or modality to be used, and frequency of service required to address the issue. If the intervention involves administration of medications, include the dose and frequency of medication administration.
    - Measurable long-term goal(s)
    - Date of POC implementation.
    - Signature, title and date (month/day/year) of the DMAS supervising qualified provider as conformation that they developed the POC.

If two or more disciplines are utilizing personal care assistant services as a part of their service plan, each discipline must develop a separate, discipline-specific plan of care signed by each DMAS qualified provider supervising the service within the scope of their license.

- A log of personal care assistant services that includes:
    - Date (month/day/year) and amount of time (total number of minutes) of the service;
    - Procedures performed;
    - Student's response to procedures including description of response if varied from normal;
    - Identification of the staff person rendering the service.

Specialized Transportation

LEAs that bill for specialized transportation must maintain documentation to support billing for each trip made. Trip is defined as the one-way transport of a covered student from (to) their home or another designated "originating site" to (from) the location where a covered services is provided. Documentation of each trip billed must include:

- Trip service date;
- The names of all students in attendance on the bus for that trip;
- Signature and date of the Driver or Bus Attendant on that trip;
- Medicaid or FAMIS ID numbers of the students enrolled in Medicaid or FAMIS; and
- Service provided connected to that trip

The LEA may only bill for transportation provided on a day that the student received a covered service.

QUALITY MANAGEMENT REVIEW (LEA)

Quality management controls are important to ensure quality of care as well as the appropriate provision of services and the medical necessity for services. Many of the review and control requirements respond to federal and state regulations; all participating providers must comply with all of the requirements.

DMAS or its contractors must provide for the continuing review and evaluation of the care and services covered by DMAS. This includes the review of the utilization of services rendered by providers to students.

Medicaid/FAMIS records of students currently receiving DMAS reimbursable services as well as a sample of closed Medicaid/FAMIS records may be reviewed. DMAS or its contractors may also conduct an on-site investigation as follow-up to any complaints received.

Periodic, unannounced, quality management review on-site visits or desk reviews will be made. Review may include but is not limited to:

- The comprehensive care being provided;
- The adequacy of the services available to meet the current health needs and to promote the maximum physical and emotional well-being of each student for the scope of services offered;
- The necessity and desirability of the continued services;
- The documentation of the services in the student's IEP to support medical necessity and authorization for services; and
- For verification of agency/provider adherence to DMAS requirements in accordance with federal and state regulations.

Upon completion of an on-site review, DMAS staff will meet with staff members for an exit conference. The exit conference will provide an overview of the findings from the review. A report will be written detailing the findings. Based on the review team's report and recommendations, DMAS may take corrective action. Actions taken and the level of management involved will be based on the severity of the cited deficiencies regarding adequacy of services.

If DMAS requests corrective action plans, the local education agency must submit the plan, within 30 days of the receipt of notice. Subsequent visits/desk reviews may be required for the purpose of follow-up deficiencies, complaint investigations, or to provide technical assistance.

FRAUDULENT CLAIMS (LEA)

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

Since payment of claims is made from both state and federal funds, submission of false or fraudulent claims, statements, or documents or the concealment of a

material fact may be prosecuted as a felony in either federal or state court. DMAS maintains records for identifying situations in which there is a question of fraud and refers appropriate cases to the Office of the Attorney General for Virginia, the United States Attorney General, or the appropriate law enforcement agency.

Provider Fraud

Providers are responsible for reading and adhering to applicable state and federal regulations and to the requirements set forth in this manual. Providers are also responsible for ensuring that all employees are likewise informed of these regulations and requirements. The Providers certify this by his or her signature or the signature of his or her authorized agent on each invoice that all information provided to the Department of Medical Assistance Services is true, accurate, and complete. Although claims may be prepared and submitted by an employee, providers will still be held responsible for ensuring their completeness and accuracy. Repeated billing irregularities or possible unethical billing practices by a provider should be reported to the following address, in writing, and with appropriate supportive evidence:

Department of Medical Assistance Services

Division of Program Integrity

Supervisor, Provider Review Unit

600 East Broad Street

Richmond, Virginia 23219

Investigations of allegations of provider fraud are the responsibility of the Medicaid Fraud Control Unit in the Office of the Attorney General for Virginia. Provider records are available to personnel from that unit for investigative purposes. Referrals are to be made to:

Office of the Attorney General

Director, Medicaid Fraud Control Unit

202 North Ninth Street

Richmond, Virginia 23219

Recipient Fraud

Allegations regarding issuance of non-entitled benefits and/or fraud and abuse by non-providers are investigated by the Recipient Audit Unit of the Department of Medical Assistance Services. The unit focuses primarily on determining whether individuals misrepresented material facts on the application for Medicaid and/or failed to report changes that, if known, would have resulted in ineligibility. The unit also investigates incidences of card-sharing and prescription forgeries.

If it is determined that non-entitled benefits were issued, corrective action is taken by referring individuals for criminal prosecution, civil litigation, or establishing administrative overpayments and seeking recovery of misspent funds. Under provisions of the Virginia State Plan for Medical Assistance, DMAS must sanction an individual who is convicted of Medicaid fraud by a court. That individual will be ineligible for Medicaid for a period of 12 months beginning with the month of the fraud conviction. The sanction period may only be revoked or shortened by court order. Referrals should be made to:

Department of Medical Assistance Services

Division of Program Integrity

Supervisor, Recipient Audit Unit

600 East Broad Street

Richmond, Virginia 23219

EPSDT Supplement B

GENERAL INFORMATION ON EPSDT SERVICES

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly. EPSDT is a Medicaid

benefit and therefore there are no special enrollment procedures for members to access EPSDT services.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements. EPSDT provides examination and treatment services at no cost to the enrollee.

DMAS, its contracted MCOs and their providers have the responsibility to provide EPSDT diagnostic and treatment services according to the DMAS periodicity schedule to all Medicaid/FAMIS fee-for-service/FAMIS Plus enrollees under age 21. The full scope of EPSDT treatment is available to all children in Medicaid/FAMIS Plus regardless of their chosen MCO. Individuals aged 19 or 20 who are covered under Medicaid expansion are eligible for EPSDT.

FAMIS

Children enrolled in the FAMIS Program are not eligible for all EPSDT treatment services. Children who are eligible for the FAMIS program must enroll with a Managed Care Organization (MCO) in most parts of the state. Although FAMIS enrollees receive well child visits, they are not eligible for the full EPSDT treatment benefit.

The EPSDT diagnostic and treatment benefit is available to FAMIS Fee-for-Service enrollees.

EPSDT Goals

The goals of EPSDT are to identify health concerns, assure that treatment is provided before problems become complex, and to medically justify that services are provided to treat or correct identified problems.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, and is composed of two parts:

- EPSDT periodic screenings or well child check-ups – checkup that should occur at regular intervals.

- EPSDT/Inter-periodic Screenings, sick visits – unscheduled check-up or problem focused assessment that can happen at any time because of illness or a change in condition.

EPSDT also covers other services, products, or procedures for children, if those items are determined to be medically necessary to "correct or ameliorate" (make better) a defect, physical or mental illness, or condition (health problem) identified through routine medical screening or examination, regardless of whether coverage for the same service or support is an optional or limited service under the state plan.

All treatment services require service authorization (before the service is rendered by the provider).

The required EPSDT services under Section 1905(r) of the Social Security Act are described below.

Screening Services

Required EPSDT screening components include:

- A comprehensive health and developmental history (including assessment of both physical and mental health development);
- A comprehensive unclothed physical exam;
- Vision screening by a standardized testing method according to the DMAS periodicity schedule;
- Hearing screening by a standardized testing method according to the DMAS periodicity schedule;
- Developmental screening with a standard screening tool according to the American Academy of Pediatrics guidelines;
- Age appropriate immunizations as needed according to the Advisory Committee on Immunization Practices (ACIP) guidelines;
- Laboratory tests (including lead blood testing at 12 and 24 months or for a new patient with unknown history up to 72 months or as appropriate for age and risk factors);
- Health Education/Anticipatory Guidance/problem-focused guidance and counseling.

The chart below indicates when a child should receive an EPSDT screening:

INFANCY	EARLY CHILDHOOD	LATE CHILDHOOD	ADOLESCENCE
3-5 days	12 months	5 years	11 years
1 month	15 months	6 years	12 years
2 months	18 months	7 years	13 years
4 months	2 years	8 years	14 years
6 months	30 months	9 years	15 years
9 months	3 years	10 years	16 years
	4 years		17 years
			18 years
			19 years
			20 years

The "EPSDT Screening Services" section located within this chapter provides detailed EPSDT screening information.

Other Necessary Health Care, Diagnostic Services and Treatment Services – Specialized Services

As with all Medicaid services, any limitation that the state imposes on EPSDT services must be reasonable and the benefit provided must be sufficient to achieve its purpose. In addition, the state must provide other necessary health care, diagnostic services, treatment and other measures listed in the Federal Medicaid statute, to correct and ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not they are covered in the state Medicaid plan. The non-state plan services are called Specialized Services.

The state may determine the medical necessity of the service and subject the service to service authorization for purposes of utilization review.

In addition to the traditional review for medical necessity, Medicaid children who are denied services that do not meet the general coverage criteria must receive a secondary review to ensure that the EPSDT provision has been considered. The DMAS, service authorization contractor, and MCO secondary review process for medical necessity must consider the EPSDT correct or ameliorate criteria. The Department must approve the MCO's second

review process for EPSDT prior to implementation or when requested. Denial for services to children cannot be given until this secondary review has been completed.

No service provided to a child under EPSDT can be denied as "non-covered", "out-of-network" and/or "experimental" unless the approved secondary review applying EPSDT criteria has been completed and determined that it is not medically necessary.

Outreach and Informing

Federal EPSDT regulations provide that all eligible Medicaid/FAMIS fee for service/FAMIS Plus members under age 21 and their families be informed of the nature and availability of EPSDT services and how to access them. Informing is accomplished through a number of outreach activities including face-to-face discussions, telephone conversations, and written communications. The purpose of outreach is to increase EPSDT screening participation.

Outreach and informing is the joint responsibility of DMAS, the Department of Social Services (DSS), participating MCOs, primary care physicians (PCPs) and EPSDT screening providers.

DSS provides the following information about EPSDT services to Medicaid applicants during the initial eligibility interview including the following:

- Informs families of the benefits of regular preventive health care for their children;
- Informs families on the range of services available, and how to obtain these services;
- Informs families that the services are provided at no cost to them; and;
- Informs families on the available necessary transportation and appointment scheduling assistance.

The Managed Care Help Line staff informs members of EPSDT services and encourages them to contact their primary care physician or a Medicaid enrolled EPSDT provider as soon as possible to schedule screening appointments for their children. DMAS also sends periodic mailings based on the member's date of birth to all Medicaid/FAMIS fee-for-service/FAMIS Plus enrolled families to encourage their participation in EPSDT.

MCO informing and outreach responsibilities must include, at a minimum, promotion of EPSDT for new enrollees, including urging them to contact their primary care provider to schedule an initial screening, a clear description of EPSDT services in the member handbook and ongoing member education services encouraging participation in these services.

DEFINITIONS

Activities of Daily Living (ADLs): Activities usually performed in the course of a normal day in an individual's life; and may include eating, dressing, bathing and personal hygiene, mobility including transfer and positioning, bowel and bladder assistance.

Administrative Dismissal:

1. A DMAS provider appeal dismissal that requires only the issuance of an informal appeal decision with appeal rights but does not require the submission of a case summary or any further informal appeal proceedings; or
2. The dismissal of a member appeal on various grounds, such as lack of a signed authorized representative form or the lack of a final adverse action from the MCO or other DMAS Contractor.

Adverse Action: The termination, suspension, or reduction in covered benefits or the denial, in whole or in part, of payment for a service.

Adverse Benefit Determination: Pursuant to 42 C.F. R. § 438.400, means, in the case of an MCO, any of the following: (i) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit; (ii) the reduction, suspension, or termination of a previously authorized service; (iii) the denial, in whole or in part, of payment for a service; (iv) The failure to provide services in a timely manner, as defined by the State; (v) the failure of an MCO to act within the timeframes provided in §438.408(b)(1) and (2) regarding the standard resolution of grievances an appeals; (vi) for a resident of a rural area with only one MCO, the denial of a member's request to exercise his or her right, under §438.52(b)(2)(ii), to obtain services outside the network; (vii) the denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities

Appeals:

1. A *member appeal* is:
    a. For members enrolled in an MCO, in accordance with 42 C.F.R. § 438.400, defined as a request for review of an MCO's internal appeal decision to uphold the MCO's adverse benefit determination. For members, an appeal may only be requested after exhaustion of the MCO's one-step internal appeal process. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

    b. For members receiving FFS services, defined as a request for review of a DMAS adverse action or DMAS Contractor's decision to uphold the Contractor's adverse action. If an internal appeal is required by the DMAS Contractor, an appeal to DMAS may only be requested after the Contractor's internal appeal process is exhausted. Member appeals to DMAS will be conducted in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370; or

2. For services that have already been rendered, a *provider appeal* is:
    a. A request made by an MCO's provider (in-network or out-of-network) to review the MCO's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. After a provider exhausts the MCO's reconsideration process, Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.; or

    b. For FFS services, a request made by a provider to review DMAS' adverse action or the DMAS Contractor's reconsideration decision in accordance with the statutes and regulations governing the Virginia Medicaid appeal process. If an adverse action requires reconsideration before appealing to DMAS, the provider must exhaust the Contractor's reconsideration process, after which Virginia Medicaid affords the provider the right to two administrative levels of appeal (informal appeal and formal appeal) in accordance with the Virginia Administrative Process Act at Code of Virginia § 2.2-4000 *et seq*. and Virginia Medicaid's provider appeal regulations at 12 VAC 30-20-500 *et seq*.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare, Medicaid and State Child Health Insurance programs.

DMAS: The Virginia Department of Medical Assistance Services (DMAS) is the state Medicaid agency that is responsible for administering the EPSDT benefit.

EPSDT (**Early and Periodic Screening, Diagnostic and Treatment):** a Federal law (42 CFR § 441.50 et seq) that requires state Medicaid programs to assure that health problems for individuals under the age of 21 are diagnosed and treated as early as possible, before the problem worsens and treatment becomes more complex and costly.

EPSDT requires a broad range of outreach, coordination and health services that are distinct from general state Medicaid requirements, EPSDT provides examination and treatment services at no cost to the enrollee.

EPSDT Screener: DMAS enrolled or contracted Medicaid MCO enrolled Physician, Physician's Assistant, or Nurse Practitioner.

EPSDT Screening: EPSDT screening services contain the following five (5) elements:

- A comprehensive health and developmental history, including assessment of both physical and mental health and development;
- A comprehensive unclothed physical examination;
- Appropriate immunizations according to the ACIP (Advisory Committee on Immunization Practice) schedule;
- Laboratory tests (including blood level assessment);
- Each encounter must be appropriate for age and risk factors, and health education, including anticipatory guidance.

FAMIS: Virginia's program that helps families provide health insurance to their children. FAMIS stands for Family Access to Medical Insurance Security Plan. FAMIS is a separate federal program from Medicaid. In Virginia, FAMIS enrollees are not eligible for some types of EPSDT specialized services when enrolled in a managed care organization.

FAMIS Plus: FAMIS Plus is the name given to the Virginia Medicaid program.

Fee for Service and Managed Care: DMAS provides Medicaid to individuals through two programs: a program utilizing contracted managed care organizations (MCO) and fee-for-service (FFS), which is the standard Medicaid program that uses the DMAS provider network to deliver healthcare services. "FAMIS fee for service" enrollees are eligible for EPSDT benefits when there is no Managed Care Organization that is contracted to serve their geographic region.

Internal Appeal: A request to the MCO or other DMAS Contractor by a member, a member's authorized representative or provider, acting on behalf of the member and with the member's written consent, for review of the MCO's adverse benefit determination or DMAS Contractor's adverse action. The internal appeal is the only level of appeal with the MCO or other DMAS Contractor and must be exhausted by a member or deemed exhausted according to 42 C.F.R. § 438.408(c)(3) before the member may initiate a State fair hearing.

Service Authorization (SA): The process of determining whether or not the service request meets all criterion for that service and gives authority to providers to allow reimbursement for services. Providers and individuals are notified of each SA decision with a system-generated notice. SA for specialized inpatient services for FFS enrollees is obtained at DMAS. SA for Managed Care enrollees must be obtained through the MCO.

State Fair Hearing: The Department's evidentiary hearing process for member appeals. Any internal appeal decision rendered by the MCO or DMAS Contractor may be appealed by the member to the Department's Appeals Division. The Department conducts evidentiary hearings in accordance with regulations at 42 C.F.R.§§ 431 Subpart E and 12 VAC 30-110-10 through 12 VAC 30-110-370.

State Plan for Medical Assistance: The set of benefits approved by the Commonwealth of Virginia and the Centers for Medicaid and Medicare Services.

Third Party Liability (TPL): Insurance other than Medicaid that is owned by the

individual or purchased on the individual's behalf. This insurance may be liable for coverage of the requested Medicaid service. TPL must be billed for services prior to billing Medicaid.

EPSDT SCREENING SERVICES

Qualified EPSDT Screening Providers

Qualified providers of EPSDT screening services include:

- A physician licensed by the Board of Medicine;
- A physician assistant licensed by the Board of Medicine under supervision as required by their license;
- A nurse practitioner licensed by the Boards of Medicine and Nursing and acting within the scope of practice;
- Federally Qualified Health Centers (FQHCs);
- Rural Health Clinics (RHCs);
- Local health departments;
- School based health clinics; and
- Other DMAS approved clinics

EPSDT providers must be Medicaid enrolled providers and must meet all applicable Medicaid provider and specific EPSDT screening requirements. There are no additional enrollment requirements for qualified providers to participate in EPSDT.

The Primary Care Physician's Role in Screening

PCPs for children in MCOs must directly provide EPSDT services for all children assigned to them. Those children who are not enrolled in managed care may obtain these services from any Medicaid enrolled physician or clinic qualified to provide EPSDT services and also offers these services. These qualified Medicaid enrolled fee-for-service EPSDT providers must follow the same requirements indicated in this manual. The Managed Care Help Line maintains a list of these providers. EPSDT is a Medicaid benefit and therefore there are no special enrollment procedures for members to access EPSDT services.

The PCP or EPSDT screening provider (both MCO and FFS), must perform the following activities related to screening services:

- Advise families of the importance of regular preventive health care for their children and explain EPSDT services.
- Provide or arrange for initial and periodic EPSDT preventive health screenings according to the DMAS periodicity schedule and screening requirements.
- Assure that the initial screening is scheduled within thirty (30) days of notification of managed care assignment and immediately upon notification of newly assigned newborns unless the services are declined.
- Notify families when the next screening is due including those families who have previously declined screening services and encourage them to keep all screening appointments.
- Schedule the next screening appointment and maintain periodicity and tracking system on screenings.
- Follow up on missed or incomplete screenings including contacting families and rescheduling the screenings promptly.
- Coordinate care for children referred to other qualified providers for screening services and specialty care and obtain results of the screenings and other health care services.
- Maintain a comprehensive and integrated medical record of all health care the child receives including complete documentation of all EPSDT screening components and immunizations given.

MCOs may assume responsibility for some of the informing, tracking and notifying functions of PCPs. One of the primary goals of DMAS' managed care programs is to promote a "medical home" for children so that members under the age of 21 receive both sick and well care from their PCP rather than seek episodic care from an emergency room. A PCP who chooses not to directly provide screening services must enter into a formal written agreement with a local health department, FQHC, or other qualified EPSDT provider to provide screening services to children in his panel. The referral duration will be at the discretion of the provider, and must be fully documented in the patient's medical record. "Exhibits" at the end of this chapter contains an optional referral form for this purpose. Regardless of the screening arrangements, the PCP must continue to be responsible for the informing, tracking, follow-up and documentation requirements of EPSDT.

The EPSDT Screening Periodicity Schedule

EPSDT screenings are Medicaid's well child visits and should occur according to the "American Academy of Pediatrics Recommendations for Preventive Pediatric Health Care".

The DMAS periodicity schedule is included as Appendix 1 under "Exhibits" at the end of this chapter. Providers must obtain a medical history that is inclusive of mental health risk factors and documents the family's history of mental health conditions.

EPSDT screenings, inter-periodic screenings and the required components of the screenings do not require service authorization requirements. However, screenings not performed by the child's PCP may require a referral from the PCP. Children not enrolled in managed care are not subject to this referral requirement.

EPSDT Screening Components

This Section describes the required components of EPSDT screenings for members enrolled in Fee for Service and Managed Care Organizations. The EPSDT comprehensive health screening/well child visit content should be in line with the most current recommendations of the **"American Academy of Pediatrics (AAP), Guidelines for Health Supervision".** Another resource for preventive health guidelines is the AAP compatible **"Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents".** All components of EPSDT screenings, including specimen collection, must be provided during the same screening visit.

The following is a description of each of the required age appropriate screening components:

Comprehensive Health and Developmental/Behavioral History

At the initial screening, the screening provider must obtain a comprehensive health, developmental/behavioral, mental health and nutritional history from the child's parents or a responsible adult familiar with the child, or directly from an adolescent, when appropriate. This history should be gathered through an interview or questionnaire. A comprehensive initial history includes a review of the:

- Family medical history (health of parents and current family members, identification of family members with chronic, communicable or hereditary diseases);
- Patient medical history (prenatal problems, neonatal problems, developmental milestones, serious illnesses, surgeries, hospitalizations, allergies and current health problems and medications);
- Nutritional history;
- Immunization history;
- Environmental risk (living conditions, water supply, lead, sewage, pets, smokers in home);
- Family background of emotional problems, problems with drinking or drugs or history

of violence or abuse; and
- Patient History of behavioral and/or emotional problems (educational environment and performance, family and social relationships, hobbies, sports).

In addition, for all adolescent children, the initial history must include:

- History of sexual activity, if appropriate
- Menstrual history for females
- Obstetrical history, if appropriate

The history must be updated at each subsequent screening visit to allow serial evaluation.

Developmental Surveillance, Assessment, and Screening

Developmental surveillance should be conducted at each well-child visit. Developmental surveillance is the process of recognizing children who may be at risk of developmental delays. Surveillance is longitudinal, continuous, and cumulative and is comprised of the following components: parental concerns; developmental history; observation of the child; identification of risk and protective factors; and accurately documenting the process and findings. The following are examples of conducting surveillance:

- Parental concerns: Simple questions to parents such as "do you have any concerns about your child's development? Behavior? Learning? Asking about *behavior* can help identify issues, as parents may not be able to differentiate between development and behavior.
- Developmental history: Ask parents about changes since the last visit, and questions about age-specific developmental milestones such as walking, pointing, etc.
- Observation: The health care provider can often see evidence of age-specific developmental milestones, and may be able to confirm parental concerns. It is also important to monitor the parent's response to the infant, and vice versa.
- Risk and protective factors: Infants born prematurely, at low or very low birth weight, or with prenatal exposure to alcohol, drugs, or other toxins are at risk for developmental delay. Protective factors to support infants at risk, such as participation in home visitation program, or strong connections within a loving and supportive family, should also be considered in determining the overall degree of risk.

Surveillance services are always a subjective observation by the practitioner. Reimbursement for well child visits includes surveillance activities because developmental, hearing and vision surveillance occurs during the course of each EPSDT visit. When a child

has an issue that warrants further investigation by the practitioner, then the child may receive a screening to document the need for further assessment or evaluation.

DEVELOPMENTAL SCREENING TOOLS

If at any time developmental surveillance demonstrates a risk for developmental delay, a standardized screening tool should be administered to further assess the child. As recommended by the AAP, developmental screening using a standardized screening tool should occur at 9, 18, 24 and 30 months of age or at any time when surveillance indicates a risk for developmental delay. An autism specific screening is recommended at the 18 and 24 month visit. Children should be screened for developmental concerns at least 5 times while they are younger than three years of age.

Developmental assessment and screening differs from surveillance because the activity of assessment and screening includes the use of a standardized developmental screening tool. The tools used may vary according to the type of screening or assessment that is provided. All of the examples listed below can be performed by a parent or other office staff and interpreted by the physician during the “face to face” portion of the child’s visit. These tools are designed to be used easily as part of the typical office work flow and the tools are very sensitive and specific with proven statistical validity.

Recommended Developmental Screening Tools

Parents' Evaluation of Developmental Status (PEDS),	Parent-report instrument used to identify general developmental delay in the general primary care population
Ages and Stages Questionnaire (ASQ),	Parent-report instrument used to identify general developmental delay in the general primary care population and/or broad high-risk population
Bayley Infant Neurodevelopmental Screen (BINS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	Parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	Practitioner-administered instrument used to identify language delay in the high-risk population

Modified Checklist for Autism in Toddlers (M-CHAT)	Parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Recommended Tools for Focused Screening for Suspected Health Conditions:

Cognitive Adaptive Test/Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CAT/CLAMS),	Practitioner-administered instrument used to identify general developmental delay in the high-risk population
Language Development Survey (LDS),	A parent-report instrument used to identify language delay in the general primary care population
Clinical Linguistic Auditory Milestone Scale Expressive and Receptive Language Scale (CLAMS),	Practitioner-administered instrument used to identify language delay in the high-risk population
Modified Checklist for Autism in Toddlers (M-CHAT)	Parent-administered instrument used to screen for autism and developmental delay in the general primary care population

Hearing and Vision Screening and Surveillance

Subjective

The subjective screening for hearing and vision is part of the comprehensive history and physical examination. Children's hearing is assessed according to the AAP policy for "Hearing Assessment in Infants and Children: Recommendations Beyond Neonatal Screening". Children's vision assessment should be provided according to the AAP policy for "Eye Examination in Infants, Children, and Young Adults by Pediatricians". Hearing and Vision screenings follow the most current AAP periodicity schedule as stated in the AAP "Recommendations for Preventive Pediatric Health Care".

The Virginia Early Hearing Detection and Intervention (EHDI) program, the AAP, and the American Speech-Language-Hearing Association provide information on objective hearing screening methods for infants and toddlers.

The EHDI program has a resource, Protocols for Medical Management, that defines best practices for caring for infants and young children who are in need of follow-up from

universal newborn hearing screening programs and for children who are found to have hearing loss. The Early Hearing Detection and Intervention protocols can be accessed the Virginia EHDI Program Web site, http://www.vahealth.org/hearing/. Early and consistent intervention specific to hearing loss is essential to achieving normal language development.

Information on vision assessment and surveillance may be found in The American Association for Pediatric Ophthalmology and Strabismus, the American Academy of Ophthalmology, and the American Academy of Pediatrics Section on Ophthalmology.

Screening and Testing Using Standardized Methods

The provision of hearing or vision testing using a standardized instrument during the well child visit is billable on that service day as a distinct service. Hearing and vision testing using a standardized instrument is eligible for reimbursement when performed according to the DMAS periodicity schedule or when required to monitor the progression of hearing or vision loss related to the presence of identified risk factors.

Virginia Law Regarding Hearing Screening at Birth

Virginia law requires that all infants receive a hearing screening before discharge from the hospital after birth. Those children who did not pass the newborn hearing screening, those who were missed, and those who are at risk for potential hearing loss should be scheduled for evaluation by a licensed audiologist.

Comprehensive Unclothed Physical Examination

A complete unclothed physical examination must be performed at each screening visit. The examination must be conducted using observation, palpation, auscultation and other appropriate techniques using the criteria for specific age groups described in the latest edition of the AAP *Guidelines for Health Care Supervision*. The examination must include all body parts (or areas) and systems listed below:

- Cranium and face
- Hair and scalp
- Ears
- Eyes
- Nose
- Throat
- Mouth and teeth
- Neck
- Skin and lymph nodes
- Chest and back (using a stethoscope) to check for heart and lung disorders

- Abdomen
- Genitalia
- Musculoskeletal system
- Extremities
- Nervous system

The examination must include screening for congenital abnormalities and for responses to voices and other external auditory stimuli. Evaluation of the Tanner stage and scoliosis screening must be included as part of the complete physical examination at each screening visit beginning at age ten.

In addition, the height (or length) and weight of the child must be measured. When examining a child two (2) years of age and younger, the provider must measure the child's occipital-frontal circumference. All measurements must be plotted on age-appropriate, standardized growth grids and evaluated.

Evaluation of growth and laboratory measures is useful for assessing nutritional status. Assessing eating habits in relationship to developmental stage is also important. If dietary or nutritional problems are identified, a referral to the appropriate professional should be made.

For children three and above, the physical examination must include blood pressure measurement.

As part of the physical examination, excessive injuries or bruising that may indicate inadequate supervision or possible abuse must be noted in the child's medical record. If there is suspicion or evidence that the child has been abused or neglected, State law requires medical professionals to promptly report it to the Department of Social Services' Hotline 1-800-552-7096 (*Code of Virginia* Section-63-248.3).

Immunizations and Laboratory Tests

Age appropriate immunizations should be provided according to the Advisory Committee on Immunization Practices (ACIP) guidelines. All "catch up" schedules for missed vaccines should follow ACIP guidelines.

The child's immunization status must be reviewed from the child's medical record and interview with the parent at each screening visit. If the immunization history is based on the verbal report of the parents or other responsible adult, the information must be confirmed and properly documented, indicating the source.

Age-appropriate immunizations that are due must be administered during the screening visit. Immunizations given to a child during a screening visit may be billed separately. PCPs and other medical screening providers are required to participate in the Virginia Vaccines for Children (VFC) Program and provide necessary immunizations and information about the benefits and risks of immunizations as part of EPSDT screenings. The PCP and screening provider must ensure that every child is immunized according to the current Childhood Immunization Schedule approved by ACIP and AAP. A parent's refusal to allow immunizations must be documented by a statement in the child's medical record that is signed and dated by the parent. If a condition is identified during the screening that warrants deferral of necessary immunizations to a later date, the progress notes in the medical record must so indicate. The provider must follow up to reschedule the child to catch up on immunizations at the earliest possible opportunity.

Vaccines for Children Program

The Vaccines for Children (VFC) Program is a federal program established in 1984 to help raise childhood immunization rates in Virginia. VFC provides federally purchased vaccine, at no cost to health care providers, for administration to eligible children. As part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program, childhood immunizations and annual pneumococcal vaccinations are covered according to the most current Advisory Committee for Immunization Practices (ACIP) schedule.

To be eligible for free vaccine from the VFC Program, children must be under the age of 19.

VFC eligible individuals must also meet one of the following criteria:

- Medicaid/FAMIS PLUS, enrolled, including Medicaid MCOs,
- Uninsured (no health insurance),
- Native American or Native Alaskans (no proof required) and
- Underinsured (those whose insurance does not cover immunizations).

Requirement to Enroll in VFC

To participate, a provider must complete the enrollment and provider profile forms provided by VDH. At this point, the provider is eligible to receive free vaccines under the VFC.

Upon enrollment, the Department of Medical Assistance Services will not reimburse the provider for the acquisition cost for vaccines covered under VFC. Medicaid will reimburse providers the administration fee for routine childhood vaccines that are available under VFC (under the age of 19). Medicaid will reimburse the provider an administration fee per injection.

Billing Codes for the Administration Fee

Providers must use Medicaid-specific billing codes when billing Medicaid for the administration fee for free vaccines under VFC. These codes identify the VFC vaccine provided and will assist VDH with its accountability plan that the Health Care Financing Administration (CMS) requires. The billing codes are provided in the Current Procedural Terminology (CPT-4) books.

Billing Medicaid as Primary Insurance

For immunizations, Medicaid should be billed first for the vaccine administration. This is regardless of any other coverage that the child may have, even if the other coverage would reimburse the vaccine administration costs. Medicaid will then seek reimbursement from other appropriate payers. When a child has other insurance, check “YES” in Block 11-D (Is there another health benefit plan?) on the CMS-1500 (08-05) claim form. See the Physician/Practitioner Manual for further instructions.

Vaccines Not Available Under VFC

The Virginia Department of Health has no contracts with the Centers for Disease Control (CDC) for the VFC distributor to provide Diphtheria Tetanus and Pertussis (DTP) and Hepatitis B for dialysis patients. Therefore, Medicaid will reimburse for the acquisition cost for these vaccines under CPT codes 90701 and 90747, respectively. No administration fee will be reimbursed under code since this vaccine is not available under VFC.

Vaccines Provided Outside of the EPSDT Periodicity Schedule

Virginia Medicaid covers childhood immunizations under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit based upon a periodicity schedule. This schedule was developed by the Advisory Committee on Immunization Practices (ACIP) and the American Academy of Pediatrics along with representatives from the American Academy of Family Physicians. If the provider provides a vaccine to a child that falls outside of this

immunization schedule and the vaccine does not meet the criteria for coverage under the VFC Program, Medicaid will not reimburse for immunizations unless documentation is sent along with the claim to explain the circumstances under which the vaccine was provided. In addition to the attachment to the claim, use modifier 22 in Locator 24-D to bill Medicaid for the acquisition cost.

Billing for Childhood Immunizations

The Federal Vaccines for Children (VFC) Program provides routine childhood immunizations free of charge to Medicaid-eligible children under the age of 19. These vaccines are provided to VFC enrolled providers by the Virginia Department of Health (VDH). DMAS requires that PCPs serving children and EPSDT screening providers participate in the VFC program. Providers may enroll in the VFC Program by contacting VDH at 1-800-568-1929. DMAS and the DMAS contracted MCOs will not reimburse providers for the acquisition cost of vaccines that are covered under the VFC Program. DMAS reimburses providers for the administration fee for routine childhood vaccines that are available under VFC (under the age of 19). DMAS will reimburse the provider an $11.00 administration fee per injection.

MCOs are responsible for provider payments of immunizations furnished to children enrolled in MCOs. Therefore, providers cannot be reimbursed by DMAS for immunizations provided to MCO enrolled children.

Reimbursement for Children Ages 19 and 20

Since EPSDT Federal regulations require states to provide coverage for vaccines for children under the age of 21, and VFC provides coverage only under the age of 19, there may be instances where the provider will provide immunizations to children who are ages 19 and 20. In these instances, the provider must use the appropriate CPT procedure code. DMAS will reimburse the acquisition cost for these vaccines. The charges in locator 24F of the HCFA 1500 (12-90) claim form must reflect the actual acquisition cost per dose. Providers should refer to Chapter V of the DMAS Physician Manual for further billing guidance.

VFC Coverage of Other Vaccines

The VFC program covers all vaccines in the ACIP immunization schedule, including indications for when a single-antigen vaccine that is normally part of a combination vaccine may be medically appropriate. Claims for single-antigen vaccines that are normally a part of a combination vaccine will automatically pend for review by DMAS staff.

Age appropriate immunizations are a federally required screening component. The provider must not submit a claim for a complete screening unless all required components that are due are administered and documented including appropriate immunizations according to age and history (unless medically contraindicated or the parents refuse at the time). Failure to comply with or properly document this screening requirement must constitute an incomplete screening and may result in denial of payments.

EPSDT REQUIREMENTS FOR LEAD TESTING

As part of the definition of EPSDT services, the Medical Statute requires coverage for children to include both screening and blood lead tests as appropriate, based on age and risk factors. The Centers for Medicare and Medicaid Services (CMS) requires all Medicaid enrolled children receive a blood lead test at 12 months and 24 months of age. In addition, any child between 24 and 72 months with no record of a previous blood lead screening test must receive one. The medical record will be deemed insufficient if the child has not been previously screened. Completion of a risk assessment questionnaire does not meet the Medicaid requirement. The Medicaid requirement is met only when the two blood lead screening tests identified above (or a catch-up blood lead screening test) are conducted

(https://www.medicaid.gov/federal-policy-guidance/downloads/cib113016.pdf).

Confirmation of Blood Lead Levels

Blood Lead level testing shall be performed on venipuncture or capillary blood; however, additional testing may be required, as described below. Filter paper methods are also acceptable and can be performed at the provider's office. The use of handheld testing machines must be approved through the Lead-Safe Virginia Program to assure proper quality assurance and reporting of data.

Tests of venous blood performed by a laboratory certified by the federal Centers for Medicare & Medicaid Services in accordance with 42 USC § 263a, the Clinical Laboratory Improvement Amendment of 1988 (CLIA-certified), are considered confirmatory. Tests of venous blood performed by any other laboratory and tests of capillary blood shall be confirmed by a repeat blood test, preferably venous, performed by a CLIA-certified laboratory. Such confirmatory testing shall be performed in accordance with the following schedule (requirements of 12VAC5-90-215):

If result of screening test (µg/dL) is:	Perform diagnostic test on venous blood within:
5-9	1- 3 months
10-44	1 week – 1 month
45-59	48 hours
60-69	24 hours
70 or higher	Immediately as an emergency lab test

For consultation and assistance on the treatment of children with elevated venous blood levels 70 or higher contact Emergency Lead Healthcare through their free medical hotline at 1-866-767-5323 (1-866-SOS-LEAD).

Lead Testing Procedure Codes

If blood lead screening tests are conducted in the providers' offices, the code 83655 for Lead blood testing is used with one of the following: 36416 or 36415, depending on whether the sample is from a capillary or venous site, as shown below.

Service Description	Procedure Code
Lead Lab Test (paid to Lab or EPSDT screener)	CPT 83655
Capillary Sample (finger, heel, ear stick)	CPT 36416
Venous Sample (recommended)	CPT 36415

When blood lead testing is provided to a client enrolled in a Virginia Medicaid Managed Care Organization (MCO), please follow the MCOs specific billing instructions.

Remember to always verify Medicaid eligibility before services are rendered.

Virginia Regulations for Disease Reporting and Control

The Virginia Regulations for Disease Reporting and Control require physicians and the directors of laboratories to report any "detectable" blood lead levels in children ages 0-15 years to the Local Health Department within 3 days.

In October 2016, these regulations were updated and "Lead, elevated blood levels" was renamed "Lead, reportable levels". "Lead, reportable levels" now means any detectable blood lead level in children 15 years of age and younger and levels greater than or equal to 5 µg/dL in a person older than 15 years of age (12VAC5-90-10). This requirement applies to test results confirmed by a CLIA-certified laboratory. Results of office-based screening tests do not need to be reported.

Many laboratories submit disease reports by means of secure electronic transmission. Reports may also be submitted by using the Epi-1 form that can be found on the Virginia Department of Health (VDH) web site at: http://www.vdh.virginia.gov/content/uploads/sites/13/2016/03/Epi1.pdf

For more information, please visit the VDH web site:

http://www.vdh.virginia.gov/surveillance-and-investigation/commonwealth-of-virginiastate-board-of-health/

Medicaid Funded Environmental Investigations

Environmental investigations are a service offered by Medicaid through Lead-Safe Virginia and local health departments. Environmental investigations are reimbursed to local health departments enrolled with DMAS or contracted with a Virginia Medicaid MCO. Medicaid funds are not available for the testing of environmental substances such as water, paint, or soil. Environmental investigations are conducted when certain criteria are met and may be carried out by private entities or environmental health specialists in local health

departments who are licensed risk assessors. For information about what triggers an environmental lead investigation and what it includes, go to http://www.vdh.virginia.gov/leadsafe.

For additional questions about environmental lead testing, contact Lead-Safe Virginia toll-free at 1-877-668-7987. You may also email Lead-Safe Virginia at leadsafe@vdh.virginia.gov.

Resources for more information about blood lead testing and lead exposure

Lead-Safe Virginia:

https://www.cdc.gov/nceh/lead/programs/va.htm

The National Lead Information Center (NLIC):

Environmental Protection Agency (EPA):

https://www.epa.gov/lead

CDC Childhood Lead Poisoning Prevention Program

https://www.cdc.gov/nceh/lead/

Coalition to End Childhood Lead Poisoning:

http://www.greenandhealthyhomes.org/StrategicPlanforEndingLeadPoisoning

Additional Laboratory Procedures

In addition to the lead toxicity screening, the following procedures on laboratory tests are required:

Neonatal Screening

The screening provider must review the results of the newborn metabolic screening for phenylketonuria, hypothyroidism, galactosemia and other disorders performed prior to hospital discharge.

Sickle Cell Screening

The screening provider must review the results of the sickle cell screening performed prior to hospital discharge on the appropriate population. A sickle cell preparation must be done at the six (6) month old visit if indicated in accordance with AAP guidelines.

Anemia Screening

Iron deficiency anemia screening involving taking hematocrit or hemoglobin values through a finger prick or venous blood sample must be performed at screening visits in accordance with AAP guidelines.

Anemia screening, is a Medicaid reimbursable service, and should be administered more frequently if medically indicated. The results can be shared with the patient's written consent if the certification is needed for the Supplemental Nutrition Program for Women, Infants and Children (WIC).

EPSDT Optional Screening Procedures

The following is a description of **optional** screening procedures to be performed on children and adolescents at risk:

Tuberculin Test (Optional)

Tuberculin testing using the Purified Protein Derivative (PPD) skin test should be performed in accordance with AAP guidelines. The PPD test has replaced the Tyne method.

Cholesterol Screening (Optional)

Cholesterol and hyperlipidemia screening should be performed at each screening visit beginning at age two in accordance with AAP guidelines.

Sexually Transmitted Disease (STD) Screening (Optional)

All sexually active adolescents should be screened for sexually transmitted diseases such as chlamydia, gonococci, and syphilis at each screening visit beginning at age 11 through age 20. HIV testing should be performed if requested or if the adolescent is at high risk.

Cancer Screening (Optional)

A Papanicolaou (Pap) smear should be performed on all sexually active females at each screening visit.

Pelvic Examination (Optional)

All sexually active females should have a pelvic examination. A pelvic examination and a Pap smear must be offered as part of preventive health maintenance between the ages of 18 and 21.

Anticipatory Guidance

Health Education, also called “Anticipatory Guidance”, and problem focused guidance and counseling are provided at each well child visit according to developmental needs and with respect to patient cultural backgrounds and literacy levels.

The **Bright Futures** program has family friendly materials that provide useful anticipatory guidance information and age appropriate safety and parenting tips. For more information on Bright Futures, go to the web based training module at http://www.vdh.virginia.gov/brightfutures DMAS endorses **Bright Futures** and **Bright Futures Virginia**.

Referral to Dental Screening

Federal EPSDT regulations require a direct referral to a dentist beginning at age three. An oral inspection must be performed by the EPSDT screening provider as part of each physical examination for a child screened at any age. Tooth eruption, caries, bottle tooth decay, developmental anomalies, malocclusion, pathological conditions or dental injuries must be noted. The oral inspection is not a substitute for a complete dental screening examination provided through direct referral to a dentist.

The PCP or other screening provider must make an initial direct referral to a dentist when the child receives his or her three-year screening. The initial dental referral must be provided at the initial medical screening regardless of the periodicity schedule on any child age three or older unless it is known and documented that the child is already receiving regular dental care. The importance of regular dental care must be discussed with the family (and child as appropriate) on each screening visit for children three (3) years and older. When any screening, even as early as the neonatal examination, indicates a need for dental services at an earlier age, referral must be made for needed dental services.

DOCUMENTATION

The screening provider must retain copies of all screening claims and other Medicaid claims for at least five years from the date of service or as provided by applicable state laws, whichever period is longer. If an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved. The PCP must maintain complete medical records on all children screened in his or her panel for at least five years from the date of service or as provided by applicable state law, whichever period is longer. Appropriate procedures and systems to ensure confidentiality must be in place. Medical records must contain the following information specific to EPSDT screening services:

- Reason for visit, e.g., screening, follow-up, sick visit. (Note the complaint and relevant history).
- The date screening services were performed, the specific tests or procedures performed, the results of these tests and procedures, and the specific staff member who provided the service. Each required component of screening including vision and hearing screening and immunizations must be documented separately. The DMAS-353, available in the provider portal, may be used for this purpose.
- Documentation of medical contraindication or a written statement from a parent or a guardian on a child screened for whom immunizations were due and not given and attempts the screening provider made to bring the child up-to-date on immunizations.
- Identification of any screening component not completed, the medical contraindication

or other reason why it could not be completed, and attempts the screening provider made to complete the screening.
- Documentation of a medical contraindication or other reason for delay in vision or hearing screening if not performed on the same day as a medical screening.
- Documentation of declination of screening services by parents.
- Documentation of missed appointments and of at least two good faith efforts to reschedule according to the periodicity schedule.
- Referrals made for diagnosis, treatment, or other medically necessary health services for conditions found in screenings and documentation of follow-up done to assure services or treatment were provided within 60 days of the screening.
- Date next screening is due.
- Documentation of direct referral for age-appropriate dental services.

SPECIAL BILLING INSTRUCTIONS

Virginia Medicaid requires the use of Health Care Financing Administration Common Procedure Coding System (HCPCS/CPT) codes and definitions published in the current edition of the *Physician's Current Procedural Terminology* (CPT) in billing EPSDT covered screenings. The CPT Manual may be obtained by calling the America Medical Association at 1-900-621-8335. The Health Insurance Claim Form, CMS-1500 (08-05) must be used to bill for screening services and immunizations. The invoice is completed and submitted according to the instructions provided in the Medicaid *Physician Manual*. Locators 24D and 24H are specific to EPSDT screening claims. **The appropriate procedure modifier is required in locator 24D for each CPT code for screenings**. **The appropriate indicator "1" is required in locator 24H**.

Referral providers authorized by a child's PCP to provide treatment or other health services to that child must enter the **Medicaid Provider Identification Number of the PCP in Locator 17a** of the CMS-1500 (08-05) in order to be reimbursed. Subsequent referrals resulting from the PCP's initial referral will also require the PCP's authorization and the PCP's Medicaid provider number in this block.

For children enrolled in MCOs, the MCO is responsible for payment of EPSDT screening services.

Billing for Developmental Screenings

Assessment and screening is a reimbursable service when a standardized screening tool is used. Providers may bill for a developmental screening or assessment, using the Current Procedural Terminology (CPT) code 96110, (E&M) visit when Modifier 25 is used along with the appropriate E&M code (CPT codes 99201-215 and 99381-395) for that visit.

Providers may use the following modifiers, when appropriate as defined by the most recent (CPT). The member's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service, and tool used that allowed the use of the modifier.

- Modifier 22 – Unusual Procedural Service: When the service provided is greater than that usually required for the procedure code. Use of this modifier will cause the claim to pend for manual review and requires an attachment to explain the use of the modifier. Physicians should not apply this modifier unless there are unusual situations that warrant manual review.
- Modifier 24 – Unrelated E&M Service by the same Physician during the post-operative period.
- Modifier 25 – Significant, separately identifiable E&M Service on the same day by the same Physician on the same day of the procedure or other services.
- Modifier 59 – Distinct Procedural Service

This section describes how to claim an EPSDT periodic screening or well-child visit and when to bill for an inter-periodic or problem focused visit in lieu of a well child visit. A list of the Current Procedural Terminology (CPT) codes used to reimburse for well child visit services is included in the "Exhibits" section of this chapter.

Screening/Well Child Billing Guidance

- **Complete Well Child/EPSDT Screening (CPT 99381-99395)**: Bill the appropriate evaluation and management (E&M) code for Preventive Medicine Services (screening) when **all services** included in the procedure code as described in the Current Procedural Technology (CPT) manual are completed and documented. Use the ICD diagnosis codes for a "healthy visit."
- **Incomplete EPSDT Screening (CPT 99381-99395)**: If screening is incomplete because the child is uncooperative, bill the E&M code for an appropriate office visit

and reschedule the child for the next appropriate EPSDT screening/well child visit. Use the ICD diagnosis code that defines the child's health status for this "problem focused" visit.

- **Problem Focused or Inter-periodic Screening "Sick Visit" (99201-99215)**: These are problem-focused screenings that are used to investigate specific health complaints and to refer children for any type of medical or mental health treatment. Use the ICD diagnosis code that defines the child's health status for this visit. The screening provider may not bill for a separate office visit for treatment of the child's illness or condition on the date a complete screening is billed.

Billing for Hearing, Vision, and Developmental Screenings During the EPSDT Well Child or Problem Focused Visit

Objective hearing screening (CPT code 92551), vision screening (CPT code 99173), and developmental assessment (CPT code 96110) procedures performed using a standardized screening method on the same date of service as a Preventive Medicine E&M will be reimbursed separately when Modifier 25 is used along with the appropriate E&M code for that visit.

Use the following modifiers, when appropriate as defined by the most recent Current Procedural Terminology (CPT). The member's medical record **must** contain documentation to support the use of the modifier by clearly identifying the significant, identifiable service that allowed the use of the modifier.

- Modifier 22 – Unusual Procedural Service: When the service provided is greater than that usually required for the procedure code. Use of this modifier will cause the claim to pend for manual review and requires an attachment to explain the use of the modifier. Physicians should not apply this modifier unless there are unusual situations that warrant manual review.
- Modifier 24 – Unrelated E&M Service by the same Physician during the post-operative period.
- Modifier 25 – Significant, separately identifiable E&M Service on the same day by the same Physician on the same day of the procedure or other services.
- Modifier 59 – Distinct Procedural Service

Billing for Special or Inter-periodic EPSDT Screenings (Medicaid Fee-for-Service Providers)

- **Missed Screenings** - If a child misses a regular periodic screening, that child may be screened at the earliest possible time to bring the child into compliance with the AAP-recommended periodicity schedule. Providers should follow billing instructions for an

EPSDT/Well Child screening.

- **Inter-periodic Screenings** - Screenings may be provided in addition to the regular periodicity schedule screenings for medical evaluation of a specific problem. Inter-periodic screenings may be billed as a sick visit however, it cannot be used to provide a school, Head Start or sports physical when a well child visit was provided earlier that year. If a screening is needed to examine a specific issue or complete a developmental or comprehensive history related to a specific medical issue, then an inter-periodic screening can be provided using the appropriate preventive medicine codes. Any caregiver, medical provider or a qualified health, developmental, or educational professional who comes in contact with the child outside of the formal health care system may request that an evaluative inter-periodic screening be performed. These screenings require a brief narrative justifying the additional inter-periodic screen in the medical record. Providers should submit inter-periodic preventive and objective screening claims with a **22** Modifier to the procedure code, attach the justification statement to the claim and write **"Attachment**" in **Locator 10D** of the CMS 1500 claim form for proper processing.

- **School Entry, Headstart, and Sports Physicals -** Headstart/school entry and participation in athletics often create opportunities to screen children who are not current for Well Child/EPSDT screenings. If the child is **not** current with the Well Child/EPSDT schedule, complete the age appropriate Well Child/EPSDT screen. If the child is current with the Well Child/EPSDT schedule, a request for a Headstart/School Entry or Sports Physical does not justify the need for an inter-periodic medical screening. Providers may document the Well Child/EPSDT screening based on the School Entrance physical forms. However the physical exam is not a covered service when the child is current with his or her well child visit schedule.

Billing for Laboratory Tests

The screening provider may bill separately for laboratory tests that are performed as part of the screening and documented in the child's medical record. DMAS will only reimburse the provider actually performing the service (i.e., physician, independent laboratory, or other facility). The screening provider may bill for incurred handling and shipping charges on the HCFA-1500 (12-90) when the specimens are sent to an outside laboratory.

Lead Testing Claims Process

A list of lead testing procedure codes is included in the "EPSDT Screening Procedure Codes" exhibit at the end of this chapter. When lead testing is provided during a well child

visit or other health care encounter, the EPSDT screener must use the lead testing procedure codes with a "25" modifier in block 24D of the CMS-1500 Claim Form. Independent Laboratories or EPSDT screeners that have an approved laboratory will bill the 83655 code when the lead test is performed.

If blood lead screening tests are conducted in the provider's offices, the code 83655 for Lead blood testing is used with one of the following: 36416 or 36415, depending on whether the sample is from a capillary or venous site.

A comprehensive list of Medicaid-enrolled lab providers may be found by contacting the DMAS Provider HELPLINE, or by accessing the DMAS web portal at http://www.dmas.virginia.gov/#/maternalepsdt.

When blood lead testing is provided to a client enrolled in a Virginia Medicaid Managed Care Organization (MCO), the provider should follow the MCOs specific billing instructions. Providers should always verify Medicaid eligibility before services are rendered. DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility. The web portal to enroll for access to this system is:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or 1-800-772-9996. Both options are available at no cost to the provider.

VFC or Immunization Billing Questions

For questions relating specifically to the VFC program vaccines, contact the Virginia Department of Health Hotline at 1-800-568-1929. The VDH Hotline is available Monday through Friday from 7:00 a.m. to 5:00 p.m. For billing questions, contact the Medicaid Provider Help Line at 1-800-552-8627.

Office Visits Billed in Conjunction with Immunizations

DMAS will reimburse physicians an appropriate minimal office visit in addition to the VFC administration fee (or acquisition cost for adolescents ages 19 and 20 only) when an immunization is the only service performed.

EPSDT REFERRALS FOR SPECIALIZED SERVICES

When an EPSDT screening indicates the need for diagnosis or treatment for a suspected condition or abnormality, the physicians' progress notes must so indicate. The child may be referred for medically necessary specialty care or other health services if the PCP or screening provider is not able to provide the treatment. If the screening provider is not the child's PCP, the screening provider must contact the child's PCP to request a referral and authorization for the treatment or other services.

The PCP must follow up on all EPSDT referrals resulting from a screening to ensure that the child receives the requested treatment or other services within 60 days and document the results in the child's medical record.

The Omnibus Budget Reconciliation Act of 1989 requires states to reimburse for medically necessary services not otherwise covered under the *State Plan* for Medicaid-eligible children up to the age of 21 when such services are needed to correct or ameliorate defects, and physical and mental illness and conditions discovered by the screening services, as long as the services are allowable under the *Social Security Act* 1905(a) and are authorized by DMAS or its contractors

Some services are available outside of the *State Plan* under *Social Security Act* Section 1915(c) through Home and Community-Based Services Waivers. Services covered under Section 1915(c) are not covered under EPSDT unless they are also allowable services under Section 1905(a). For more information on Home and Community-Based Waivers, providers may contact the DMAS Provider Call Center at 1-800-552-8627 or refer to http://www.dmas.virginia.gov/#/ltss

SERVICE AUTHORIZATION FOR SPECIALIZED SERVICES

Any treatment service that is not otherwise covered under the State's Plan for Medical Assistance can be covered for a child through EPSDT as long as the service is allowable under the Social Security Act Section 1905(a) and the service is determined by the Department of Medical Assistance Services (DMAS) or its contractor as medically

necessary. Treatment services that are approved through the EPSDT benefit but are not available through the State Plan for Medical Assistance are called EPSDT Specialized Services.

Reimbursement for EPSDT specialized services is limited to the hours of treatment and medical or clinical supervision as specified in the treatment plan and as approved by DMAS or its contractors. All specialized service requests require physician documentation outlining the medical necessity, frequency and duration of the treatment. To qualify for reimbursement through the EPSDT benefit EPSDT specialized services must be approved before the service is rendered by the provider. Please see Appendix A to this supplement for additional information.

Detailed information on the service authorization of behavioral therapy, nursing, personal care inpatient services and audiology and hearing aid services defined as “Specialized Services” under EPSDT is available in separate EPSDT chapters and Appendix A available on the DMAS web portal at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. DMAS or its contractor service authorizes other services through the EPSDT benefit such as Residential Treatment for persons with developmental and behavioral challenges, hospital based services to treat neurological conditions, bariatric related treatment, treatment for eating disorders and treatment for other chronic health conditions. The services available through EPSDT are not limited to those listed. Please see Appendix A for additional information.

Chiropractic Services

Chiropractic services are available for Medicaid members under the age of 21 and through the DMAS EPSDT benefit. This service cannot be authorized for Medicaid members age 21 and older. Chiropractors (Provider Type 026) are the only providers to submit these requests. DMAS or its contractor will apply McKesson InterQual® to certain services and DMAS criteria where McKesson InterQual® products do not exist. If unable to approve a request, then DMAS or its contractor will apply EPSDT criteria. The Chiropractic CPT codes requiring service authorization are listed below.

Chiropractic CPT codes to submit for service authorization:

98940 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, ONE TO TWO REGIONS

98941 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, THREE TO FOUR REGIONS

98942 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); SPINAL, FIVE REGIONS

98943 CHIROPRACTIC MANIPULATIVE TREATMENT (CMT); EXTRASPINAL, ONE OR MORE REGION

Please see Appendix A for additional service authorization information.

Review of Items Denied Under DME for Coverage through EPSDT

In addition to the traditional review of requests for Durable Medical Equipment and Supplies (DME), children enrolled in either FAMIS Plus and FAMIS Fee for Service who are initially denied services under the DME program will receive a secondary review for these items using the EPSDT "correct or ameliorate" approval criteria. Some of these services will be approved by the DMAS service authorization contractor under the already established criteria for that specific item/service and will not require a separate review under EPSDT; some service requests may be denied using specific item/service criteria and need to be reviewed under EPSDT; and some may be referred to DMAS by its contractor on a case-by-case basis. Specific information regarding the methods of submission for children enrolled in FFS may be found at the contractor's website, https://dmas.kepro.com/. The contractor may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329. Providers should contact the MCO for DME requests for children enrolled in managed care.

For additional information on the service authorization of DME, please see Appendix D of the DME Provider Manual. A copy of this manual is available on the DMAS Medicaid web portal.

Service Authorization Status:

DMAS offers a web-based Internet option (ARS) to access information regarding Medicaid or FAMIS eligibility, claims status, check status, service limits, service authorization, and pharmacy prescriber identification. The DMAS web portal to enroll for access to this system is https://www.virginiamedicaid.dmas.virginia.gov/wps/portal. The MediCall voice response system will provide the same information and can be accessed by calling 1-800-884-9730 or

1-800-772-9996. Both options are available at no cost to the provider.

ASSISTIVE TECHNOLOGY

To correct or ameliorate physical or mental conditions identified during EPSDT screening services, the child may be referred by the EPSDT screener or PCP for Assistive Technology services. Assistive Technology is defined as specialized medical equipment, supplies, devices, controls, and appliances not available under the Virginia *State Plan for Medical Assistance.* Assistive Technology items directly enable individuals to increase their abilities to perform ADLs or to perceive, control, or communicate with the environment in which they live. Assistive Technology items are expected to be portable.

To meet the definition of Assistive Technology, requested items must meet all of the following requirements. Assistive Technology must:

- be able to withstand repeated use;
- be primarily and customarily used to serve a medical purpose and be medically necessary and reasonable for the treatment of the individual's disability or to improve a physical or mental condition;
- generally be not useful to a person in the absence of a disability, physical or mental condition; and
- be appropriate for use in both the home and community.

Equipment or supplies already covered by the Virginia *State Plan for Medical Assistance* may not be requested for reimbursement under EPSDT. A list of covered items is located in the Durable Medical Equipment and Supplies Provider Manual that is available on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual. Providers may use the "Medicaid DME and Supplies Listing" located in Appendix B of this manual to ascertain whether an item is covered through the Virginia *State Plan for Medical Assistance* before requesting the item through EPSDT. Equipment and supplies must be provided by a DME provider or assistive technology provider.

Criteria

Only Assistive Technology items that are determined to be medically necessary may be covered for reimbursement by DMAS. The following criteria must be satisfied through the submission of adequate and verifiable documentation satisfactory to DMAS. Assistive Technology must be:

- Ordered by a physician to correct or ameliorate physical or mental conditions identified during EPSDT screening services;
- A reasonable and medically necessary part of a treatment plan;
- Consistent with the individual's diagnosis and medical condition, particularly the functional limitations and symptoms exhibited by the individual;
- Not furnished solely for the convenience of the family, attending physician, or other practitioner or supplier;
- Consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and
- Provided at a safe, effective, and cost-effective level that is suitable for use by the individual.

Assistive Technology must involve direct support to the individual and be for the express purpose of diagnosing, treating or preventing (or minimizing the adverse effects of) illness, injury or other impairments to an individual's physical or mental health. Therefore, services that do not involve direct support to the individual or environmental services dealing exclusively with an individual's surroundings rather than the individual are not covered. Further, even if the requested service does involve some direct support for the individual, it cannot be covered unless the device is related to the diagnosis given as the reason for the service request.

Home/Environmental modifications do not meet the definition of Assistive Technology and are not covered under EPSDT services. Environmental modifications are defined as physical adaptations to an individual's home, primary place of residence, vehicle, or workplace. Examples of environmental modifications include but are not limited to devices that are permanently affixed to the walls of the home such as grab bars, ramps, barrier free lifts, and widening of doorways.

Individuals and caregivers are responsible for determining if the individual is receiving the appropriate Assistive Technology in the school system and suggesting that the child's Individualized Education Plan (IEP) include Assistive Technology. In cases where Assistive Technology is requested for use during school hours and not included in the IEP, the provider must obtain documentation from the school indicating why the Assistive Technology is not included in the child's IEP. Items covered under the Individuals with Disabilities Education Act (IDEA) cannot be covered under EPSDT. For information regarding Medicaid covered school services, please see the School Health Services Manual located on the DMAS website at https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual.

Service Authorization Requirements

All Assistive Technology items must be authorized by DMAS or its contractor. Service authorization for children enrolled in Managed Care must be obtained through the MCO. Please see Appendix A for additional information. Each Assistive Technology item must be recommended and determined appropriate to meet the individual's needs by a qualified professional such as an occupational therapist, physical therapist, speech language pathologist or behavioral consultant.

Medical documentation must provide a clear understanding of the individual's needs. Documentation for each requested Assistive Technology item must identify:

- The medical need for the requested Assistive Technology;
- The diagnosis related to the reason for the Assistive Technology request;
- The individual's functional limitation and its relationship to the requested Assistive Technology item;
- How the Assistive Technology item will treat the individual's medical condition;
- The quantity needed and the medical reason the requested amount is needed;
- The frequency of use;
- The estimated length of use of the item;
- Any conjunctive treatment related to the use of the item;
- How the needs were previously met and identifying changes that have occurred which necessitate the Assistive Technology request;
- Other alternatives tried or explored and a description of the success or failure of these alternatives;
- How the Assistive Technology item is required in the individual's home or community environment; and
- The individual's or caregiver's ability, willingness, and motivation to use the Assistive Technology item.

Provider Documentation Requirements

Documentation requirements include:

1. Supporting documentation, which includes the need for the service, the process to obtain this service (contacts with potential vendors or contractors, or both, of service, costs, etc.); and the time frame during which the service is to be provided. This includes separate notations of evaluation, design, labor, and materials.

2. Written documentation which proves that the item was requested and was not approved by the Virginia *State Plan for Medical Assistance* as Durable Medical Equipment and Supplies;
3. Documentation of the date services are rendered and the amount of service needed;
4. Any other relevant information regarding the device or modification;
5. Documentation of the satisfaction of the individual and/or the individual's family with the service
6. Instructions regarding any warranty, repairs, complaints, or servicing that may be needed. and
7. The individual's or caregiver's ability to use the Assistive Technology item effectively.

Specific information regarding the methods of submission for individuals enrolled in FFS are found at the contractor's website, https://dmas.kepro.com/ The contractor may also be reached by phone at 1-888-VAPAUTH or 1-888-827-2884, or via fax at 1-877-OKBYFAX or 1-877-652-9329.

There are no automatic renewals of service authorizations. Providers must submit a service authorization request if a member requires continued services or the current authorization will end without renewal. All authorizations should be submitted prior to the first date services are rendered or prior to the last day of the current authorization in order for submissions to be timely and to avoid any gaps in service.

For additional information on the service authorization process, please refer to Appendix A to this Supplement.

MEDICAL FORMULA COVERED AS DURABLE MEDICAL EQUIPMENT (DME)

The Early Periodic Screening Diagnosis and Treatment (EPSDT) benefit allows the Virginia Department of Medical Assistance Services (DMAS) to provide medically necessary formula and medical foods to EPSDT eligible children under the age of 21 based on medical necessity. The current DMAS Durable Medical Equipment (DME) provider manual defines EPSDT formula approval criteria in Chapter 4 of that manual. Routine infant formula is not covered. DMAS will reimburse for medically necessary formula and medical foods when used under physician direction to augment dietary limitations or provide primary nutrition to individuals via enteral or oral feeding methods.

Medical formula and nutritional supplements must be physician recommended to correct or ameliorate a health condition that requires specialized formula and medical foods to

supplement diet due to metabolic limitations or provide primary nutrition to individuals via enteral or oral feeding methods. Enrollees under the age of five may receive medical formula and nutritional supplements through either a local Women, Infants and Children (WIC) office or a DMAS enrolled DME provider. If the individual is enrolled in the WIC program, they also receive nutrition education services and checkups as well as referrals to other services that can help the family. Individuals enrolled in Medicaid may already financially qualify for WIC. When a local WIC office provides the formula for children under the age of five then the WIC program forms are used to document medical necessity. Please refer to the DME provider manual for additional information.

OTHER RELATED PROGRAMS

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

WIC is a supplemental food and nutrition education program that provides vouchers for the purchase of specific nutritious foods and provides nutrition counseling to pregnant, postpartum, or breastfeeding women and children under age five with nutritional and financial needs. PCPs and EPSDT screening providers must refer Medicaid-eligible individuals in these categories to the local health department for additional information and eligibility determination.

Head Start

Head Start is a federally funded pre-school program which serves low-income children and their families.

There are four major components in Head Start as follows:

- Education¾Head Start's educational program is designed to meet the individual needs of each child. It also aims to meet the needs of the community served and its ethnic and cultural characteristics;
- Health¾Head Start emphasizes the importance of early identification of health problems. Since many children of low-income families have never seen a doctor or dentist, Head Start provides every child with a comprehensive health care program, including medical, dental, mental health, and nutritional services. The comprehensive EPSDT screening will meet the requirements of the Head Start Program health assessment;
- Parent Involvement¾Parents are the most important influence on a child's development. Parents are encouraged to participate in the Head Start program as volunteers or paid staff as aides to teachers and other staff members. Many parents serve as members of Policy Councils and committees and have a voice in administrative and managerial decisions;

- Social Services¾The social services component of Head Start represents an organized method of assisting families to assess their needs, and then providing those services that will build upon the individual strengths of families to meet those needs. Some of the activities that the social services staff use to assist families to meet their needs are: community outreach; referrals; family needs assessments; providing information about available community resources and how to obtain and use them; recruitment and enrollment of the children; and emergency assistance and/or crisis intervention.

Early Intervention Program

Early intervention services are identified in the Part C amendment to the Individuals with Disabilities Education Act (IDEA). Part C provides for a discretionary grant program for states to plan, develop and implement a statewide, comprehensive, coordinated, interagency system of early intervention services to infants and toddlers with disabilities and their families.

Infant & Toddler Connection of Virginia/DMAS Early Intervention Program

The Infant & Toddler Connection of Virginia assists families of infants and toddlers with developmental delays and/or disabilities to help their children learn and develop through everyday activities and routines so that they can participate fully in family and community activities. Since there are no income limits for this program, all children who meet the early intervention eligibility criteria and who are under the age of three are eligible to receive early intervention services. In order to take advantage of the services and supports available, families need to know about the system and how to access these resources. More information can be found about the Infant & Toddler Connection of Virginia at: http://www.infantva.org/

Who is eligible for the Infant and & Toddler Connection of Virginia?

Infants and toddlers with 25% or greater delay in one or more developmental area(s):

Cognitive, adaptive, receptive or expressive language, social/emotional, fine motor, gross

motor vision, hearing development

Infants and toddlers with atypical development – as demonstrated by atypical/

questionable:

Sensory-motor responses, social-emotional development, or behaviors, or impairment in social interaction and communication skills along with restricted and repetitive behaviors

Infants and toddlers with a diagnosed physical or mental condition that has a high

probability of resulting in developmental delay:

e.g., cerebral palsy, Down syndrome or other chromosomal abnormalities, central nervous system disorders, effects of toxic exposure, failure to thrive, etc.

Instructions about how to refer children to the Infant and & Toddler Connection may be found online at: http://www.infantva.org/documents/pr-ReferralGuide.pdf

The referral form for the Infant & Toddler Connection is attached to this document and it can be found online at: http://www.infantva.org/documents/forms/3094eEI.pdf

For more information, contact:

Infant & Toddler Connection of Virginia

DBHDS, 9th Floor

1220 Bank Street

PO Box 1797

Richmond, Va. 23218-1797

(804)786-3710

(804)371-7959 Fax

www.infantva.org

Smart Beginnings

Virginia's Plan for Smart Beginnings brings together the public agencies, private agencies and organizations that support Virginia's children and families to ensure that these efforts are both effective and well coordinated. The purpose of Virginia's Plan for Smart Beginnings is to build and sustain a system in Virginia to support parents and families as they prepare their children to arrive at kindergarten healthy and ready to succeed. More information regarding this program can be found at www.smartbeginnings.org.

PROVIDER SCREENING REQUIREMENTS

All providers must now undergo a federally mandated comprehensive screening before their application for participation or contract is approved by the MCOs, Behavioral Health Services Administrator (BHSA), a DMAS contracted Medicare and Medicaid Plan (MMP) or DMAS. Screening is also performed on a monthly basis for any provider who participates with Virginia Medicaid. A full screening is also conducted at time of revalidation, in which every provider will be required to revalidate at least every 5 years.

The required screening measures are in response to directives in the standards established by Section 6401(a) of the Affordable Care Act in which CMS requires all state Medicaid agencies to implement the provider enrollment and screening provisions of the Affordable Care Act (42 CFR 455 Subpart E). These regulations were published in the Federal Register, Vol. 76, February 2, 2011, and were effective March 25, 2011. The required screening measures vary based on a federally mandated categorical risk level. Providers categorical risk levels are defined as "limited", "moderate" or "high". Please refer to the table in the Exhibits of this chapter for a complete mapping of the provider risk categories and application fee requirements by provider class type.

Limited Risk Screening Requirements

The following screening requirements will apply to limited risk providers: (1) Verification that a provider or supplier meets any applicable Federal regulations, or State requirements for the provider or supplier type prior to making an enrollment determination; (2) verification that a provider or supplier meets applicable licensure requirements; and (3) federal and state database checks on a pre- and post-enrollment basis to ensure that providers and suppliers continue to meet the enrollment criteria for their provider/supplier type and that they are not excluded from providing services in federally funded programs.

Moderate Risk Screening Requirements

The following screening requirements will apply to moderate risk providers: Unannounced pre- and/or post-enrollment site visits in addition to those screening requirements applicable to the limited risk provider category listed above. The screening requirements listed in this section are to be performed at the time of initial enrollment and at the time of revalidation, which is at least every five years.

High Risk Screening Requirements

In addition to those screening requirements applicable to the limited and moderate risk provider categories listed above, providers in the high risk category may be required to undergo criminal background check(s) and submission of fingerprints. These requirements apply to owners, authorized or delegated officials or managing employees of any provider or supplier assigned to the “high” level of screening. At this time, DMAS is awaiting guidance from CMS on the requirements of criminal background checks and finger prints. All other screening requirements excluding criminal background checks and finger prints are required at this time.

Application Fees

All newly enrolling (including new locations), re-enrolling, and reactivating institutional providers who are enrolling with DMAS or the BHSA and meet the provider types indicated in the Appendix of this Chapter are required to pay an application fee set forth in Section 1866(j)(2)(C) of the Social Security Act and 42 CFR 455.460. If a provider class type is required to pay an application fee, it will be outlined in the Virginia Medicaid web portal provider enrollment paper applications, online enrollment tool, and revalidation process. Providers shall refer to the specific MCOs and MMPs for any additional requirements. The Centers for Medicare and Medicaid Services (CMS) determine what the application fee is each year. This fee is not required to be paid to Virginia Medicaid if the provider has already paid the fee to another state Medicaid program or Medicare, or has been granted a hardship approval by Medicare.

Providers may submit a hardship exception request to CMS. CMS has 60 days in which to approve or disapprove a hardship exception request. If CMS does not approve the hardship request, then providers have 30 days from the date of the CMS notification to pay the application fee or the application for enrollment will be denied. An appeal of a hardship exception determination must be made to CMS as described in 42 CFR 424.514.

Out-of-State Provider Enrollment Requests

Providers that are located outside of the Virginia border and require a site visit as part of

the Affordable Care Act are required to have their screening to include the passing of a site visit previously completed by CMS or their State's Medicaid program prior to enrollment in Virginia Medicaid. If your application is received prior to the completion of the site visit as required in the screening provisions of the Affordable Care Act (42 CFR 455 Subpart E) by the entities previously mentioned above, then the application will be rejected.

REVALIDATION REQUIREMENTS

All providers will be required to revalidate at least every 5 years. The revalidation of all existing providers will take place on an incremental basis and will be completed via the contracted MCO, MMP, the BHSA or DMAS. Providers will receive written instructions from the MCOs, MMPs, the BHSA or DMAS regarding the revalidation process, revalidation date and the provider screening requirements in the revalidation notice. If a provider is currently enrolled as a Medicare provider, the MCOs, MMPs, BHSA and DMAS may rely on the enrollment and screening facilitated by CMS to satisfy the provider screening requirements.

ORDERING, REFERRING AND PRESCRIBING (ORP) PROVIDERS

Code of Federal Regulations 455:410(b) states that State Medicaid agencies must require all ordering or referring physicians or other professionals providing services under the State plan or under a waiver of the plan to be enrolled as participating providers.

The ACA requires ordering, referring, and prescribing providers to enroll only to meet new ACA program integrity requirements designed to ensure all orders, prescriptions or referrals for items or services for Medicaid beneficiaries originate from appropriately licensed practitioners who have not been excluded from Medicare or Medicaid. The only exception to this requirement is if a physician is ordering or referring services for a Medicaid beneficiary in a risk-based managed care plan, the provider enrollment requirements are not applicable to that ordering or referring physician.

If a provider does not participate with Virginia Medicaid currently but may order, refer or prescribe to Medicaid members, the provider must now be enrolled to ensure claims will be paid to the servicing provider who is billing for the service.

As a servicing provider, it is essential to include the National Provider Identifier (NPI) of any ORP on all claims to ensure the timely adjudication of claims.

PARTICIPATION REQUIREMENTS

All providers enrolled in the Virginia Medicaid Program must adhere to the conditions of participation outlined in their Participation Agreements/contracts, provider contracts, manuals, and related state and federal regulations. Providers approved for participation in the MCOs, MMPs and BHSA provider network must perform the following activities as well as any others specified by DMAS:

- Immediately notify DMAS, the MCOs, MMPs and the BHSA in writing whenever there is a change in the information that the provider previously submitted. For a change of address, notify DMAS, the MCOs, MMPs and the BHSA prior to the change and include the effective date of the change; Once a health care entity has been enrolled as a provider, it shall maintain, and update periodically as DMAS, the MCOs, MMPs and the BHSA require, a current Provider Enrollment Agreement for each Medicaid service that the provider offers.
- Use the MCOs, MMPs, BHSA and DMAS designated methods for submission of charges;
- Assure freedom of choice to individuals in seeking medical care from any institution, pharmacy, or practitioner qualified to perform the service(s) required and participating in the Medicaid Program at the time the service is performed;
- Assure the individual's freedom to reject medical care and treatment;
- Comply with Title VI of the Civil Rights Act of 1964, as amended (42 U.S.C. §§ 2000d through 2000d-4a), which requires that no person be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance on the grounds of race, color, or national origin;
- Provide services, goods, and supplies to individuals in full compliance with the requirements of the Rehabilitation Act of 1973, as amended (29 U.S.C. § 794), which states that no otherwise qualified individual with a disability shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance. The Act requires reasonable accommodations for certain persons with disabilities;
- Provide services and supplies to individuals of the same quality and in the same mode of delivery as provided to the general public;
- Charge the MCOs, MMPs, BHSA and DMAS for the provision of services and supplies to individuals in amounts not to exceed the provider's usual and customary charges to the general public;
- Not require, as a precondition for admission, any period of private pay or a deposit from the individual or any other party;
- Accept as payment in full the amount reimbursed by DMAS. 42 CFR § 447.15 provides that a "State Plan must provide that the Medicaid agency must limit participation in the Medicaid Program to providers who accept, as payment in full, the amount paid by

the agency". The provider should not attempt to collect from the individual or the individual's responsible relative(s) any amount that exceeds the usual Medicaid allowance for the service rendered. For example: If a third-party payer reimburses $5.00 of an $8.00 charge, and Medicaid's allowance is $5.00, the provider may not attempt to collect the $3.00 difference from Medicaid, the individual, a spouse, or a responsible relative. The provider may not charge the MCOs, MMPs, BHSA, DMAS or an individual for broken or missed appointments;

- Accept assignment of Medicare benefits for dual eligible Medicaid enrolled individuals;
- Accept Medicaid payment from the first day of eligibility if the provider was aware that an application for Medicaid eligibility was pending at the time of admission;
- Reimburse the individual or any other party for any monies contributed toward the individual's care from the date of eligibility. The only exception is when an individual is spending down excess resources to meet eligibility requirements;
- Maintain and retain business and professional records that document fully and accurately the nature, scope, and details of the health care provided; In general, such records must be retained for a period of at least five years from the date of service or as provided by applicable state laws, whichever period is longer. However, if an audit is initiated within the required retention period, the records must be retained until the audit is completed and every exception resolved;
- Furnish to authorized state and federal personnel, in the form and manner requested, access to records and facilities;
- Disclose, as requested by DMAS, all financial, beneficial, ownership, equity, surety, or other interests in any and all firms, corporations, partnerships, associations, business enterprises, joint ventures, agencies, institutions, or other legal entities providing any form of health care services to Medicaid members; and
- Hold information regarding Medicaid enrolled individuals confidential. A provider shall disclose information in his/her possession only when the information is used in conjunction with a claim for health benefits or the data is necessary for the functioning of the state agency. DMAS shall not disclose medical information to the public.
- Obtain separate provider identification numbers for each physical or servicing location wanting to offer services to Virginia Medicaid members.

PROVIDER RESPONSIBILITIES TO IDENTIFY EXCLUDED INDIVIDUALS AND ENTITIES

In order to comply with federal regulations and Virginia Medicaid policy, providers are required to ensure that Medicaid is not paying for any items or services furnished, ordered, or prescribed by excluded individuals or entities. Medicaid payments cannot be made for items or services furnished, ordered, or prescribed by an excluded physician or other authorized person when the person or entity furnishing the services either knew or should have known about the exclusion. This provision applies even when the Medicaid payment itself is made to another provider, practitioner, or supplier that is not excluded, yet affiliated

with an excluded provider. A provider who employs or contracts with an excluded person or entity for the provision of items or services reimbursable by Medicaid may be subject to overpayment liability as well as civil monetary penalties.

All providers are required to take the following three steps to ensure Federal and State program integrity:

1. Screen all new and existing employees and contractors to determine whether any of them have been excluded.
2. Search the HHS-OIG List of Excluded Individuals and Entities (LEIE) website monthly by name for employees, contractors and/or entities to validate their eligibility for Federal programs. See below for information on how to search the LEIE database.
3. Immediately report to the contracted MCOs, MMPs and the BHSA any exclusion information discovered. Such information should also be sent in writing and should include the person or business name, provider identification number (if applicable), and what, if any, action has been taken to date. The information should be sent to:

DMAS

Attn: Program Integrity/Exclusions

600 E. Broad St, Suite 1300

Richmond, VA 23219

E-mail to: providerexclusions@dmas.virginia.gov

APPEALS

Individual's Right to Appeal and Fair Hearing

The Code of Federal Regulations at 42 CFR §431 *et seq.*, and the Virginia Administrative Code at 12VAC30-110-10 through 370, require that written notification be provided to individuals when DMAS or any of its contractors takes an action that affects the individual's receipt of services. Most adverse actions may be appealed by the Medicaid client or by an authorized representative on behalf of the individual. Adverse actions include partial approvals, denials, reductions in service, suspensions, and terminations. Also, failure to act

on a request for services within required timeframes may be appealed. For individuals who do not understand English, a translation of appeal rights that can be understood by the individual must be provided.

If an appeal is filed before the effective date of the action, services may continue during the appeal process. However, if the agency's action is upheld by the hearing officer, the individual will be expected to repay DMAS for all services received during the appeal period. For this reason, the individual may choose not to receive continued services. The provider will be notified by DMAS to reinstate services if continuation of services is applicable. If coverage is continued or reinstated due to an appeal, the provider may not terminate or reduce services until a decision is rendered by the hearing officer.

Appeals must be requested in writing and postmarked within 30 days of receipt of the notice of adverse action. The individual or his authorized representative may write a letter or complete an Appeal Request Form. Forms are available on the internet at www.dmas.virginia.gov, at the local department of social services, or by calling (804) 371-8488.

A copy of the notice or letter about the action should be included with the appeal request.

The appeal request must be signed and mailed to the:

Appeals Division

Department of Medical Assistance Services

600 E. Broad Street, 11th floor

Richmond, Virginia 23219

Appeal requests may also be faxed to: (804) 371-8491

The normal business hours of DMAS are from 8:00 a.m. through 5:00 p.m. Documents received after 5:00 p.m. on the deadline date shall be untimely.

Provider Appeals of Adverse Actions

State-Operated Provider

The following procedures will be available to state-operated providers when DMAS takes adverse action which includes termination or suspension of the provider agreement or denial of payment for services rendered. State-operated provider means a provider of Medicaid services that is enrolled in the Medicaid program and operated by the Commonwealth of Virginia.

A state-operated provider has the right to request a reconsideration of any issue that would be otherwise administratively appealable under the State Plan by a non-state operated provider. This is the sole procedure available to state-operated providers.

The reconsideration process will consist of three phases: an informal review by the Division Director, a further review by the DMAS Agency Director, and a Secretarial review. First, the state-operated provider must submit to the appropriate DMAS Division Director written information specifying the nature of the dispute and the relief sought. This request must be received by DMAS within 30 calendar days after the provider receives a Notice of Program Reimbursement (NPR), notice of proposed action, findings letter, or other DMAS notice giving rise to a dispute. If a reimbursement adjustment is sought, the written information must include the nature of the adjustment sought, the amount of the adjustment sought and the reason(s) for seeking the adjustment. The Division Director or his/her designee will review this information, requesting additional information as necessary. If either party so requests, an informal meeting may be arranged to discuss a resolution.

Any designee shall then recommend to the Division Director whether relief is appropriate in accordance with applicable laws and regulations. The Division Director shall consider any recommendation of his/her designee and render a decision.

The second step permits a state-operated provider to request, within 30 days after receipt of the Division Director’s decision, that the DMAS Agency Director or his/her designee review the Decision of the Division Director. The DMAS Agency Director has the authority to take whatever measures he/she deems appropriate to resolve the dispute.

The third step, where the preceding steps do not resolve the dispute to the satisfaction of

the state-operated provider, permits the provider to request, within 30 days after receipt of the DMAS Agency Director's Decision, that the DMAS Agency Director refer the matter to the Secretary of Health and Human Resources and any other Cabinet Secretary, as appropriate. Any determination by such Secretary or Secretaries shall be final.

Provider Reconsiderations and Appeals (MCO and FFS)

Non-State Operated Provider

For services that have been rendered, providers have the right to appeal adverse actions. However, before appealing to the Department, providers must first exhaust any MCO's or DMAS Contractor's reconsideration process. Providers in an MCO's network may not appeal enrollment or terminations decisions made by the MCO to the DMAS Appeals Division. Providers enrolled with DMAS through the DMAS Contractor may appeal enrollment or termination decisions made by the DMAS Contractor to DMAS once they have exhausted the reconsideration process with the DMAS Contractor.

Provider appeals to DMAS will be conducted in accordance with the requirements set forth in Virginia Code § 2.2-4000 *et. seq.* and 12 VAC 30-20-500 *et. seq.*

All provider appeals to DMAS must be submitted in writing and **within 30 calendar days** of the provider's receipt of the DMAS adverse action or the MCO's or DMAS Contractor's adverse reconsideration decision. The provider's notice of informal appeal is considered filed when it is date stamped by the DMAS Appeals Division. The notice must identify the issues in the reconsideration decision being appealed. Failure to file a written notice of informal appeal within 30 calendar days of receipt of the MCO's or DMAS Contractor's reconsideration decision shall result in an administrative dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed to (804) 452-5454

The Department of Medical Assistance Services normal business hours are from 8:00 a.m. to 5:00 p.m. Eastern time. Any documentation or correspondence submitted to the DMAS Appeals Division after 5:00 p.m. shall be date stamped on the next day the Department is officially open. Any document that is filed with the DMAS Appeals Division after 5:00 p.m. on the deadline date shall be untimely.

Any provider appealing a DMAS informal appeal decision must file a written notice of formal appeal with the DMAS Appeals Division **within 30 calendar days** of the provider's receipt of the DMAS informal appeal decision. The notice of formal appeal must identify each adjustment, patient, service date, or other disputed matter that the provider is appealing. Failure to file a written notice of formal appeal within 30 calendar days of receipt of the informal appeal decision shall result in dismissal of the appeal. The notice of appeal must be transmitted to:

Appeals Division

Department of Medical Assistance Services

600 East Broad Street

Richmond, VA 23219

Appeal requests may be faxed to (804) 452-5454.

The provider may appeal the formal appeal decision to the appropriate circuit court in accordance with the Administrative Process Act at Va. Code § 2.2-4025, *et. seq*. and the Rules of Court.

The provider may not bill the member for covered services that have been provided and subsequently denied by DMAS.

EXHIBITS

Please use this link to search for DMAS Forms:

https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderFormsSearch

TABLE OF CONTENTS

EPSDT SCREENING PROCEDURE CODES

DESCRIPTION	Age	CPT

Code

INITIAL SCREENINGS

NEWBORN CARE (outpatient)	Normal newborn care	99432
NEW PATIENT	less than 1 year of age	99381*
NEW PATIENT	1-4 years of age	99382*++
NEW PATIENT	5-11 years of age	99383*
NEW PATIENT	12-17 years of age	99384*
NEW PATIENT	18-20 years of age	99385*

PERIODIC SCREENINGS

ESTABLISHED PATIENT	less than 1 year of age	99391*
ESTABLISHED PATIENT	1-4 years of age	99392*++
ESTABLISHED PATIENT	5-11 years of age	99393*
ESTABLISHED PATIENT	12-17 years of age	99394*
ESTABLISHED PATIENT	18-20 years of age	99395*

DEVELOPMENTAL TESTING (Instrument, Interpretation/Report)

SCREENING	0-20	96110
EXTENDED	0-20	96111

LEAD TESTING (Mandatory at 12 mos. and 24 mos. of age)

TESTING	0-20	83655
COLLECTION VENOUS SAMPLE	0-20	36415
COLLECTION CAPILLARY SAMPLE	0-20	36416
SPECIMEN HANDLIING	0-20	99000

VISION SCREENINGS

VISION	3-20 years of age	99173

HEARING SCREENING

HEARING	0-20 years	92551

Use of the appropriate CPT modifiers on the claim should be indicated as previously defined within this chapter or CPT.

**Use appropriate Immunization Codes for scheduled immunizations*

++ Lead Testing required at 12 and 24 months

Provider Risk Category Table

Application	Rule Risk Category	App Fee Requirement Yes (Y) or No (N)
Comprehensive Outpatient Rehab Facility (CORF)	Moderate	Y
Hospital	Limited	Y
Hospital Medical Surgery Mental Health and Mental Retarded	Limited	Y
Hospital Medical Surgery Mental Retarded	Limited	Y
Hospital TB	Limited	Y
Long Stay Hospital	Limited	Y
Long Stay Inpatient Hospital	Limited	Y
Private Mental Hospital(inpatient psych)	Limited	Y
Rehab Outpatient	Limited	Y
Rehabilitation Hospital	Limited	Y
Rehabilitation Hospital	Limited	Y
State Mental Hospital(Aged)	Limited	Y
State Mental Hospital(less than age 21)	Limited	Y
State Mental Hospital(Med-Surg)	Limited	Y
Audiologist	Limited	N
Baby Care	Limited	N
Certified Professional Midwife	Limited	N
Chiropractor	Limited	N
Clinical Nurse Specialist - Psychiatric Only	Limited	N
Clinical Psychologist	Limited	N
Licensed Clinical Social Worker	Limited	N
Licensed Marriage and Family Therapist	Limited	N
Licensed Professional Counselor	Limited	N
Licensed School Psychologist	Limited	N
Nurse Practitioner	Limited	N
Optician	Limited	N
Optometrist	Limited	N
Physician	Limited	N
Physician	Limited	N
Physician	Limited	N
Podiatrist	Limited	N
Psychiatrist	Limited	N
Psychiatrist	Limited	N
Substance Abuse Practitioner	Limited	N
Ambulance	Moderate	Y
Ambulance	Moderate	Y
Durable Medical Equipment (DME)	Moderate - Revalidating High - Newly Enrolling	Y
Emergency Air Ambulance	Moderate	Y
Emergency Air Ambulance	Moderate	Y
Hearing Aid	Limited	N
Home Health Agency - State Owned	Moderate - Revalidating High - Newly Enrolling	Y
Home Health Agency - Private Owned	Moderate - Revalidating High - Newly Enrolling	Y
Hospice	Moderate	Y
Independent Laboratory	Moderate	Y
Local Education Agency	Limited	N
Pharmacy	Limited	N
Prosthetic Services	Moderate - Revalidating High - Newly Enrolling	Y
Renal Unit	Limited	Y
Adult Day Health Care	Limited	N
Private Duty Nursing	Limited	N
Federally Qualified Health Center	Limited	Y
Health Department Clinic	Limited	N
Rural Health Clinic	Limited	Y
Developmental Disability Waiver	Limited	N
Alzheimer's Assisted Living Waiver	Limited	N
Treatment Foster Care Program	Limited	N
Qualified Medicare Beneficiary (QMB)	Limited	N
ICF-Mental Health	Limited	Y
ICF-MR Community Owned	Limited	Y
ICF-MR State Owned	Limited	Y
Intensive Care Facility	Limited	Y
Skilled Nursing Home	Limited	Y
SNF-Mental Health	Limited	Y
SNF-MR	Limited	Y
Psych Residential Inpatient Facility	Limited	Y
Consumer Directed Service Coordination	Limited	N
Personal Care	Limited	N
Respite Care	Limited	N
Personal Emergency Response System	Moderate - Revalidating High - Newly Enrolling	Y
Case Management DD Waiver	Limited	N
CMHP Transition Coordinator	Limited	N
Transition Coordinator	Limited	N
PACE	Limited	N
Family Caregiver Training	Limited	N
Mental Retardation Waiver	Limited	N
Mental Health Services	Moderate - Revalidating High - Newly Enrolling	Y - only for Mental Health Clinics
Early Intervention	Limited	N
Group Enrollment	Limited	N
Group Enrollment	Limited	N
Ambulatory Surgical Center	Limited	Y
Ordering, Referring, or Prescribing Provider	Limited	N